# *Creating* PARTNERSHIPS *that work*

*A Developmental Manual for Ryan White Title II HIV Care Consortia*

May, 1995

*Prepared for:* U.S. Department of Health and Human Services
Public Health Service

Health Resources and Services Administration
Bureau of Health Resources Development
Division of HIV Services

*Prepared by:* John Snow, Inc.
Ryan White CARE Act Technical Assistance Contract
#240-93-0046

# ACKNOWLEDGEMENTS

This manual is the result of a collaborative effort between the staff of the Bureau of Health Resources Development (BHRD) of the Health Resources and Services Administration (HRSA); the staff of John Snow, Inc. (JSI); people working with HIV care consortia throughout the country as consortia members, staff or consultants; and, staff of state public health agencies receiving funds through Title II of the Ryan White CARE Act.

Special recognition is extended to

**Principal Authors**

*Patricia Fairchild, John Snow, Inc. (JSI); Teresa Frydryk, JSI; Elizabeth Randall-David, Consultant; Donna Yutzy, Consultant.*

**HRSA Contributors and Reviewers**

*Warren Buckingham, Division of HIV Services (DHS); Margaret DiClemente, DHS; Miguel Gomez, DHS; Martha McKinney, Office of Science and Epidemiology (OSE); Scott Thompson, DHS; Steven Young, DHS.*

**Title II Grantees and Consortia Contributors and Reviewers**

*Carolyn Harley, North Carolina Department of Environment, Health and Natural Resources; Randall Pope, Michigan Department of Public Health; James Welch, Delaware Division of Public Health; Laura Mrosla, Eastern Triad HIV Consortium; Ellie Perzel, Regional HIV Consortium; Charlie O'Malley, Napa County HIV Care Consortium; William Arnold, Title II National AIDS Consortium; Kimberly Scott, Eastern North Carolina HIV/AIDS Consortium; Diane Seyl, Ventura County Public Health Department.*

**JSI Contributors and Production Staff**

*Marina Blanter, Katherine Cruise, Stewart Landers, Laura Purdom, Eve Wittenberg.*

**Editors**

*Ann Goodsell and Susan Lawrence.*

We appreciate the time, energy and knowledge each person contributed to the preparation of this manual.

# Table of Contents

# ABBREVIATIONS

**AETC** AIDS Education and Training Center

**AHEC** Area Health Education and Training Center

**AIDS** Acquired immuno-deficiency syndrome

**ASO** AIDS services organization

**BHRD** Bureau of Health Resources Development (within HRSA)

**CARE** Comprehensive AIDS Resources Emergency [Act of 1990]

**CBO** Community-based organization

**CDC** Centers for Disease Control and Prevention

**CMHS** Center for Mental Health Services

**DHHS** Department of Health and Human Services

**DHS** Division of HIV Services (within the HRSA BHRD)

**EMA** Eligible Metropolitan Area (for Title I) of the CARE Act

**HIV** Human immuno-deficiency virus

**HOPWA** Housing Opportunities for People with AIDS

**HRSA** Health Resources and Services Administration (within DHHS)

**HUD** Housing and Urban Development

**ITB** Invitation to bid

**PLWA** Persons living with AIDS

**RFA** Request for applications

**RFP** Request for proposals

# INTRODUCTION

This manual is a response to numerous requests from groups across the country for information to facilitate the development and operation of HIV care consortia. It is intended for individuals and organizations contemplating the formation of new coalitions, as well as those already participating in HIV care consortia.

The manual focuses on consortia funded through Title II of the Ryan White CARE Act of 1990. Such consortia currently range from informal groups of motivated individuals to legally constituted corporations. The Ryan White CARE Act specifies only that consortia receiving funds under Title II consist of at least one public and one private entity. It does not require consortia to become formal incorporated organizations, and in fact most consortia operate as unincorporated bodies.

Regardless of their organizational structures, successful consortia share certain guiding principles and fundamental attributes. This manual draws on the experiences of consortia founded prior to or immediately following passage of the CARE Act. It also incorporates fundamental principles of organizational development and nonprofit management. In keeping with the spirit of the CARE Act, our goal is to offer guidelines that are broadly applicable and useful but not prescriptive. Furthermore, the manual is designed to be applicable to all types of organizational structures.

The Ryan White CARE Act of 1990 authorizes states receiving funds to "establish and operate HIV care consortia within areas most affected by HIV disease that shall be designed to provide a comprehensive continuum of care to individuals and families with HIV disease." Specifically, such consortia are to plan, develop and deliver (directly or through agreements with others) comprehensive outpatient health and support services for individuals with HIV disease. States reporting 1 percent or more of the total number of U.S. AIDS cases in the two-year period preceding the fiscal year of the grant are required to establish consortia. Over 41 states, as well as Puerto Rico and Washington, D.C., have elected to use at least a portion of Title II funds to support HIV care consortia. Almost 300 HIV care consortia are in various stages of development nationwide.

In brief, the manual addresses how to approach the mandates and functions of a care consortium, how to structure and operate a consortium and how to improve organizational processes and dynamics. It focuses on structural and operational

## Summary of Ryan White CARE Act, Section 2613 (c): Grants to Establish HIV Care Consortia

**1**

A care consortium consists of an association of one or more public, and one or more nonprofit private, health care and support service providers and community-based organizations. These providers and organizations should have a record of service to people with HIV disease and be representative of and located in areas where infected populations reside. There should be only one consortium in a geographic area except where unique service needs of sub-populations within the area cannot be adequately addressed by a single consortium.

**2**

Consortia are required to assess the needs of populations and sub-populations within the consortium service area and to establish a service plan that addresses the special care and service needs of each population identified. Persons with HIV disease shall be involved in the assessment of needs and development of service plans. Furthermore, planning shall specifically address the needs of families with HIV disease.

**3**

Consortia must agree to use assistance provided through Title II for the planning, development and delivery, either directly or through agreements with other entities, of comprehensive outpatient health and support services. Consortia must assure that service needs are addressed through the coordination and expansion of existing programs before new programs are created. They must promote the coordination and integration of community resources and assure continuity of services through effective case management.

**4**

Consortia must create a mechanism to evaluate the success of the consortium in responding to identified needs and the cost-effectiveness of the mechanisms used to deliver comprehensive care. While the legislation spells out broad organizing principles for HIV care consortia, it is silent on most specific day-to-day operations. It provides no guidance, for instance, about such matters as geographic scope, organizational structure or operations. This nonprescriptive approach permits each state to respond to the epidemic in light of its own needs and capabilities and has led to unique and creative variations in how consortia have been organized and how they operate.

issues because they are the foundation for effectively conducting the work of a consortium.

Other material developed or under development by the Division of HIV Services (DHS) will complement this manual. Two important documents are 1) a Self-Assessment Tool for planning councils and consortia, which will provide assistance in evaluating process and outcomes with respect to mission, representation and diversity, needs assessment processes, priority setting and resource allocation and continuum of care; and 2) a Resource Manual for Newly Eligible Metropolitan Areas (EMAs), which, while designed for Title I grantees and planning councils, includes general background information on the CARE Act legislation, the Division of HIV Services within HRSA, conducting needs assessments, setting priorities and preparing applications.

The manual is organized around frequently-asked questions. These questions seldom have hard-and-fast answers, and there are usually several variable responses possible. Typically there are several possibilities, depending on the consortium's organizational structure, target geographic area or population, stage of development and other factors. When multiple issues need to be addressed in order to answer the question, the manual identifies those issues. Sometimes—especially when experience mandates a particular approach—the manual examines the pros and cons of various approaches. The examples provided (of bylaws, for example) are intended as starting points for local discussion and not as recommendations.

The various sections of the manual are free-standing; it need not be used sequentially or in its entirety. Feel free to read only the sections that are pertinent to the consortium's current concerns.

# CHAPTER ONE

# 1

# 1. Initial Decisions

Often HIV care consortia are started by small groups of motivated people who come together on an informal basis with the aim of improving services to people with HIV/AIDS. These groups quickly find, however, that they must address some central issues in order to pursue their goals effectively. As decisions are made, the consortium begins to take shape. The most fundamental of these decisions pertain to

- the mission of the consortium.
- the geographic area that the consortium will serve.
- the composition of the consortium's membership.
- how decisions will be made and who will make them.
- how Ryan White CARE Act funds will be managed.

Consortium development is an evolving process. Decisions made at start-up will probably change as the consortium develops and implements the Ryan White legislation more fully. In fact, the organizational mission, objectives and procedures should be reviewed periodically as a prudent measure and to assure continued responsiveness to the needs of the affected communities. In anticipation of such changes, the founding members' initial groundwork should be flexible.

Avoid spending excessive time at the outset second-guessing every future problem. Falling into the "what if . . ." trap early on will only provoke frustration and delay the tasks at hand—conducting a needs assessment, developing a comprehensive service plan, assuring delivery of services and instituting a process for evaluating the performance of the consortium and any subcontractors.

### What is the consortium's mission?

Consortia funded by Title II of the CARE Act exist to support and facilitate the provision of coordinated, comprehensive health and support services to people infected and affected by HIV/AIDS. The mission of each consortium should encompass this reason for being. Some representative mission statements follow:

---

THE MISSION of this consortium is to coordinate the network of resources and expertise available to people living with HIV/AIDS in . . . counties.

THE MISSION . . . is to foster and promote effective communication, collaboration, cooperation and advocacy through a comprehensive, integrated approach that meets with compassion and dignity the multifaceted needs of persons affected by HIV/AIDS.

THE MISSION . . . is to improve the visibility, accessibility, responsiveness, and effectiveness of health and human services . . . . The underlying rationale for our mission is that the highest quality of overall services can generally be delivered through a thoughtful coordinated effort.

THE MISSION . . . is to assure and facilitate access to high quality health and supportive services for people infected with HIV/AIDS by contracting with existing providers and coordinating services through the provision of case management and care coordination assistance.

---

The mission provides guidance for the development of the specific goals and activities the consortium will pursue. Because it frames the work of the consortium, the mission should be developed through an inclusive process, involving the infected and affected populations, health and social service providers and community leaders. Often the mission needs to be revisited and perhaps restated as membership expands.

The mission of a care consortium must, at minimum, enable the consortium to undertake the five responsibilities prescribed in the legislation: (1) assess the service needs of different populations with HIV, (2) develop a plan for meeting these needs through a "comprehensive continuum" of outpatient medical and support services, (3) promote the coordination and integration of community resources, (4) assure continuity of services through effective case management and (5) periodically evaluate the consortium's effectiveness in responding to service needs. The consortium may also assume other responsibilities such as distributing funds to service providers, planning prevention and education activities or soliciting funds outside Title II.

*See Chapter 2 on Responsibilities of Consortia.*

### What geographic area should the consortium cover?

Consortia cover geographic areas ranging from a single county to multiple counties to an entire state. The Title II grantee (the state) frequently determines the geographic area to be covered by different consortia. Additionally, the following issues should be considered when deciding whether the consortium should be a single or multi-jurisdictional organization:

- Number and type of social service providers available in the area
- Number of medical providers available in the area
- Relationships between public health officials and the community
- Locations of care and treatment currently available to clients
- Political and social environment
- History of adjoining jurisdictions in working together
- Community resources available
- Funding allocation amounts
- Local infrastructure capacity
- Distance and ease of travel
- Availability of community members to participate in the consortium

Multi-jurisdictional or regional consortia—those that cover more than one county or jurisdiction, including statewide consortia—differ operationally from single-county consortia. Regional consortia must develop their service-delivery plans with multi-county input, leadership,

authority and planning. Generally speaking, there are two alternative approaches to this process:

- A regional consortium may "pool" its funds and develop a regional plan.
- Each local jurisdiction may convene a committee or task force to develop a local plan for a portion of the total funds. Its recommendations are sent to the regional consortium's governing body, which filters them through the consortium's decision-making process.

Both processes present challenges. Regional consortia coordinate multiple health jurisdictions, which may or may not have a history of collaboration. Furthermore, the plan that a regional consortium develops must give fair representation to all participating jurisdictions, including the smallest county. Small counties often complain that they have no voice in decision making in regional consortia. Even such simple decisions as where to hold meetings have an impact on the level of participation. Without equal representation, consortia run the risk of disproportionately appropriating funds to the larger counties in the consortium. Sometimes a regional consortium is preferable because its existence may help to dilute hostile or unsupportive political or social environments in a small rural county—thereby guaranteeing services for clients who reside in that county.

A primary advantage of a regional consortium may be its ability to deliver a more comprehensive array of services through the aggregate allocation of funds. Regional consortia can also be organized around normal service delivery patterns when, for example, significant HIV services are provided by a single hospital for several counties. When resources are scarce, as in many rural areas, regional consortia may also result in more service options being available.

One of the biggest differences between regional and single-county consortia involves personnel. Often, regional consortia can afford paid employees because they pool resources. Many single-county consortia, by contrast, cannot afford staff.

On the other hand, single-county consortia may be able to develop more streamlined organizational models because there are fewer political jurisdictions involved. Decision making generally involves a shorter timeline. However, there are single-county consortia with service areas as large as some states. Issues of distance, transportation and travel to meetings are as pronounced for them as for regional consortia. There is no right or wrong model of consortium development. Each community must assess its own needs and decide on the approach that best meets those needs.

### Who will constitute the consortium?

The consortium process promotes community involvement, which is essential to provide equal access to high-quality, cost-effective direct client services for all people infected and affected by HIV/AIDS.

Also, the CARE Act requires participation of individuals with HIV disease.

The consortium's goal should be to develop diverse and inclusive membership in order to mobilize resources from as many sectors of the community as possible. It is also critical that the points of view of infected populations be well represented. Membership decisions, in turn, should create equal participation in the consortium. A diversified and inclusive consortium will encourage access for

- people infected with and affected by HIV, including PLWA, family members, significant others, caregivers and advocates.
- communities most affected or at high risk for HIV and their advocates, including gay men, homeless persons, incarcerated people, injection drug users and their partners, sex workers, hemophiliacs and their partners and adolescents.
- providers of health and social services needed by PLWA, including primary and specialty care, substance abuse counseling and treatment, mental health services, home care, acute care, long-term care, housing, case management, emergency assistance and child care.
- funders (individuals, corporations and foundations).
- elected officials and legislators at the city, county and state levels.
- other publicly-funded HIV/AIDS related programs, including Medicaid, other CARE Act-funded services, clinical trials, HIV/AIDS and sexually transmitted disease prevention programs and tuberculosis prevention/treatment programs.
- professionals, including lawyers, accountants, physicians and specialists in grant-writing, evaluation, marketing and public relations, finance, personnel and health planning.
- representatives of religious communities, educational institutions, civic groups, AIDS services organizations and community-based organizations.

*See Chapter 6 on Membership.*

### How will decisions be made and who will make them?

Some consortia adopt a democratic vote process based on majority rule. Others assign decision making to committees that report to the full membership or to a board of directors. Still others employ consensus decision making.

Whatever the decision-making process chosen, anyone should be eligible to raise an issue for discussion and decision. Successful consortia promote participation by all of their members. This does not mean that every member must participate in every decision, or that every member agrees with every decision. The decision-making process should, however, be recognized and accepted by the membership.

**The decision-making process typically involves the following steps**

*(adapted from How to* Make Decisions that Stay Made *by Saphier, Bigda-Peyton and Pierson , 1989)*

1. Identify the issue. Who owns it? What is the purpose?
2. Discuss the issue. Identify advantages and disadvantages.
3. Decide who should coordinate the decision-making process.
4. Communicate clearly to the membership who will make the decision, and identify constraints such as staffing, budgeting and time that will affect the scope and content of the decision. Explicitly state the values to be adhered to and why they are not negotiable.
5. Identify the consequences of the various possible decisions.
6. Solicit opinions from representative parties affected by the decision.
7. Decide.
8. Communicate the decision to all affected parties, summarizing its main points, the conflicts raised and the recommendations.
9. Consider a process for revisiting the decision.
10. Plan how to monitor and support day-to-day implementation of the decision. Communicate these plans to everyone.

Consortia that choose democratic voting must decide whether to adopt a one-person/one-vote or a one-agency/one-vote process. One-agency/one-vote can make for poor representation of various divisions of larger agencies such as public health departments. With one-person/one-vote, members who represent two agencies will not be able to register a vote for both groups. Consortia must also decide whether to limit the number of voting representatives from any single agency and whether agencies can substitute voting representatives—is the vote tied to the person or the agency?

Choices about process and representation are influenced by the organizational structure adopted by the consortium and the specific task that the decision making addresses.

*See Chapter 5 on Organizational Options.*
*See Chapter 12 on Grievance Procedures.*

## How will consortium funds be managed?

A major decision facing a consortium is whether to manage its own funds, typically as an incorporated 501(c)3 organization, or whether to use a lead or fiscal agency—we will use the terms interchangeably—to manage its funds. Most consortia have not incorporated; instead they rely on existing agencies to serve a lead role, especially in the early stages of consortium development.

Typically, consortium development begins with the selection of a lead agency to convene meetings and coordinate start-up activities, including (1) developing the service plan, budgets and statistical reports and (2) preparing and monitoring any subcontracts.

The lead agency may be a state or county health department, a community foundation, a public trust like the United Way, a community-based organization (CBO), an AIDS services organization (ASO), an incorporated nonprofit agency or another entity. Typically, the lead agency has experience with and commitment to HIV service delivery. Often but not always, the lead agency becomes an integral part of the consortium as it becomes operational by participating in consortium membership and committees and sometimes by providing services.

In some consortia, however, lead agencies have evolved solely as fiscal and/or administrative agents. Some states require groups that are not incorporated as 501(c)3 organizations to designate an incorporated lead agency to receive and distribute Title II funds and to provide administrative oversight.

Criteria to consider when selecting a lead agency to serve as a fiscal agent include

- commitment to HIV issues.
- fiscal-management experience.
- cash-flow reserves.
- experience of accountability to a wide array of organizations and funders.
- ability to collect, store and retrieve data about services.

In addition to serving as fiscal and administrative agents, lead agencies may also play a role in HIV service delivery as case managers or providers of other services. When lead agencies are also service providers, issues about conflict of interest may arise. These are discussed more fully in Chapter 10.

The decision to use a lead agency or to incorporate as a 501(c)3 organization is a complicated one. It is discussed more fully in Chapters 3 and 4 on Organizational Options and Bylaws. Related issues of fiscal accountability are also discussed in Chapter 3.

*See Chapter 3 on Organizational Options.*

# CHAPTER TWO

# 2

# 2. Responsibilities of Consortia

**What are the responsibilities of a consortium?**

Some consortium responsibilities are prescribed in the legislation; others are delegated by the state, and still others are assumed by the consortium in response to needs in its service area.

A summary of legislatively required responsibilities and some optional responsibilities follows.

Each of these levels of involvement requires an in-depth discussion of successful approaches; such a discussion is beyond the scope of this manual. Additional material being developed by DHS, including self-assessment tools and a possible second volume of this manual, will address successful approaches to fulfilling consortium responsibilities in more detail.

**What is needs assessment?**

Title II of the CARE Act requires that the consortium carry out an assessment of service needs within the geographic area to be served. Needs assessments are to include the participation of individuals and families with HIV disease, and are to be conducted in collaboration with public health and community-

**Responsibilities required in legislation:**

- conducting needs assessments
- planning and setting service priorities
- promoting coordination and integration of community resources
- assuring the provision of comprehensive outpatient health and support services
- evaluating the success and cost-effectiveness of the consortium in responding to service needs

**Possible additional responsibilities:**

- distributing and monitoring funds for HIV services
- soliciting additional sources of funding
- providing a mechanism for collaboration among local HIV task forces, education and prevention community planning groups, state HIV planning entities and other advisory councils
- establishing service standards
- providing case management or other services
- educating the community about HIV/AIDS
- becoming the umbrella organization for all HIV/AIDS planning in the community, including prevention
- serving as an advisory body to local government agencies
- providing management and support services to participating organizations
- advocating for enhanced HIV services


- providing case management or other services
- educating the community about HIV/AIDS
- becoming the umbrella organization for all HIV/AIDS planning in the community including prevention
- serving as an advisory body to local government agencies
- providing management and support services to participating organizations
- advocating for enhanced HIV services

based and other agencies that provide HIV-related services.

The purpose of a needs assessment is to identify gaps and shortfalls in service and to form the basis of planning and priority setting. Conducting reliable needs assessments with limited resources is challenging. Working closely with entities that already have data on HIV epidemiology and services is essential to minimize data collection efforts. State and local health departments, AIDS Service Organizations (ASOs), AIDS Education and Training Centers (AETCs), community health centers (CHCs), community-based health and social service providers, hospitals, and other health care providers and local colleges and universities may be sources of information and personnel to help with needs assessment.

Needs assessment may be informal or formal, and is usually some mix of both. Formal methods include analysis of existing information and conducting surveys, focus groups, telephone or face-to-face interviews and public hearings. These formal methods may yield both quantitative and qualitative information. Informal methods, such as raising questions about need at meetings and collecting anecdotal information through conversations with clients or service providers, yield additional qualitative information. Whenever possible, consortia should use both qualitative and quantitative approaches in their needs assessments.

### What is involved in planning and setting priorities for services?

The CARE Act requires that consortia establish a plan to ensure the delivery of services to meet identified needs. Participation of people infected with HIV is required in the planning process.

Planning and setting priorities for services require weighing need against the resources available to meet it. If a need is almost impossible to meet, it may not figure prominently in a final plan or list of priorities. Among the factors to be taken into account in planning is the practicality of offering a particular service, the ability of existing providers to develop the service, the availability of non-Title II funding for the service, the cost-effectiveness of the service and the potential impact of offering or not offering the service on individual clients and on the overall service delivery system. Development of a plan based on these and other considerations may be structured in a variety of ways, but must balance openness and inclusiveness with timely creation of a final product.

### What is involved in coordination of services?

The CARE Act requires that consortia address HIV service needs through the coordination and expansion of existing resources before new programs are created. Consortia are also expected to assure access to a continuum of care through case management services.

Coordination of services is an important and necessary outgrowth of bringing together a wide variety of provider organizations and community representatives in a single organization. A consortium develops an institutional memory of the services being provided by its members and will frequently use consortium meetings to learn more about those services. Face-to-face relationships often facilitate referrals between service providers who have not previously worked together. Many consortia have created resource directories of available services to increase awareness of and access to services. Consortia have worked on coordinating issues, such as how to facilitate referral while protecting confidentiality, reducing paperwork related to intake procedures, minimizing duplication of services and assuring access to specific services (buddy programs, housing search, legal assistance, etc.) regardless of the client's entry point into the system.

### What is involved in assuring the provision of health and support services?

The CARE Act requires that consortia provide for the delivery of a broad range of health and support services either by entering into agreements with existing agencies or by providing services directly. The list of services that can be supported with Title II funds is extensive, which is precisely why the planning, priority-setting and coordination functions of consortia are so important.

Most care consortia provide services through agreements or contracts with existing service providers. *Activities of Ryan White CARE Act Title II HIV Care Consortia, FY 1995* (Conviser, 1994) reports that consortia had an average of about five contracts with service providers, with the number of contracts ranging from zero to 69. Services are provided in all categories permitted through the legislation, the most frequently provided being case management, support services, primary care and treatments and medication. Dental care, mental health and home health services are also frequently provided.

Assuring the provision of health and support services requires the development and maintenance of a comprehensive service delivery network and the implementation of a case management system to ensure that clients have appropriate access to those services.

*See Chapter 9 on External Relationships.*

### How do consortia evaluate their success?

The CARE Act requires that consortia have a mechanism to periodically evaluate their success in responding to identified needs and the cost-effectiveness of their approaches to delivery of comprehensive care.

Evaluation activities to assess the consortium's effectiveness in responding to service needs examine outcome measures such as the availability and accessibility of services, client satisfaction and quality of

services. Some consortia also evaluate the satisfaction of their members with the process of the consortia, including issues such as representation, decision making and the allocation of resources. Evaluation of the cost-effectiveness of different approaches to delivering services can be built into the processes of competitively awarding funds to service providers by, for example, considering the cost of service as one decision element. In addition, a consortium should periodically assess its own administrative structure and procedures to ensure that it is operating cost-effectively. Evaluation can be relatively quick and inexpensive or resource-intensive. Consortium staff, grantee staff or outside consultants may evaluate both services and the consortium processes.

### Will the consortium be responsible for allocating funds to service providers?

In most states, the consortium is the decision maker with respect to the allocation of Title II funds in its geographic area. Grantees (states) allocate funds through an incorporated consortium or a lead agency on behalf of an unincorporated consortium. The consortium controls the allocation of resources either directly or through the lead agency. Direct services not provided by the consortium are subcontracted. One process to allocate funds to subcontractors is competitive bidding. This approach requires the consortium to establish a process to issue a Request for Proposal (RFP), review proposals, determine awardees, grant funds and oversee the use of funds. A second method of subcontracting is to determine the services that are needed and contract with vendors to provide those services on a sole-source basis. This approach may be acceptable when there is only one service provider capable of or willing to provide a needed service. Finally, some consortia use an allocation formula to distribute funds. This procedure is most common when a consortium is allocating money to another umbrella organization, such as a county task force, which may then further subdivide the resources among direct service providers. Appendix A outlines several approaches for distributing funds to service providers and includes a sample RFP.

There is potential for conflict of interest when consortia have responsibilities for allocating funds. Because the CARE Act requires that providers be part of consortia, decision makers within consortia are frequently employees, board members or clients of the agencies seeking resources to provide services. Close attention must be paid to conflict of interest in all phases of the resource-allocation and program-monitoring processes, and policies and procedures must be in place to minimize this problem.

*See Chapter 10 on Conflict of Interest.*

In some states, Title II consortia are planning entities that become advisory to the grantee for final decision making regarding the allocation of funds. In this model the grantee makes final decisions about the use of Title II funds based on

the advice, input, plans and priorities of the consortium. In this arrangement, funds may still flow through a fiscal agent. However, it is more likely that funds will be allocated directly to service providers who are reimbursed directly by the grantee. Consortia influence the delivery of services through their coordination and planning functions, but the contractual relationship is between the grantee and the direct service delivery organization.

Statewide consortia most frequently act as planning groups and provide advice about the need for services. They work on an ongoing basis with the grantee to improve existing services and to identify the new services most needed to improve the continuum of care. In at least one state (Delaware) the consortium is the decision-making body and the state works in partnership with the consortium. In general, statewide consortia are found in states with a relatively low incidence of AIDS cases. A thorough discussion of the variety of consortia appears in *Assessing Needs and Coordinating Care: A NASTAD Review of State Decision-Making Processes Under Title II of the Ryan White CARE Act* (U.S. DHHS HRSA Division of HIV Services, 1994).

### How will the availability of funds be announced to potential service providers?

Mailings to the consortium's mailing list, known service providers and providers listed in local directories of health and human service providers or in the Yellow Pages are likely to be most productive. Other approaches include announcements in local newspapers, public service announcements on the radio and distribution of flyers or brochures to consortium members' clients and families and to community leaders.

### What guidelines or criteria should be used to select service providers?

The specific criteria employed are less important than that they are chosen and agreed upon by the consortium's membership, clearly communicated to prospective providers and adhered to in the selection process. Possible selection criteria could include the following:

- **Fiscal Management**
  - incorporation as legal business entity
  - availability of current audited financial statements
  - reasonableness of budget
  - cost-effectiveness
  - other sources of funding
- **Fiscal Management**
  - clearly defined and measurable goals and objectives
  - relevance to consortium's priorities based on needs assessment
  - clearly articulated and quantifiable methods of evaluation
  - client grievance policies
- **Service Capabilities**
  - established access to target population

- experience in HIV/AIDS service delivery
- availability of staff and facilities for services proposed
- demonstrated history of cooperation and collaboration with other service providers
- established standards of care
- participating Medicaid provider

Once criteria have been selected, points or a percentage should be assigned to each criterion. The reviewers can then assign a score to each application. (For example: Target population = 20 points; Methods of evaluation = 20 points; Capability = 30 points; Cooperation and collaboration = 20 points, and Budget = 10 points. Minimum passing score = 70 points.)

### Who will select the service providers?

A committee usually reviews proposals or applications. The committee may have final decision-making authority, or it may make recommendations to a designated person (such as the chairperson) or body (such as the board) for final decision. Whichever approach is chosen, the review committee exercises a great deal of power. It is therefore crucial that it be composed of people committed to pursuing sound decisions and free of competing interests. The review committee may, for example, be composed of community members unaffiliated with the consortium or potential service providers. Alternatively, it may consist of board members from another agency, such as the United Way or the Red Cross, if they have no affiliation with the consortium or potential service providers.

Another approach is for members of the consortium without conflict of interest to handle the selection process. Some consortia use an outside review committee to score the applications. Final decisions about the level of funding for each eligible provider are then made by consortium members without conflicts of interest.

### Can the consortium use Title II funds to support its operations?

The clear purpose of consortium funding is to enhance the provision of services to people infected and affected by HIV. Costs for administration and consortium operations should be kept low. The legislation caps at 10 percent the proportion of Title II funds a state may spend on administrative costs. This percentage, or another cap, may be passed on to consortia. A consortium should check with the state agency responsible for administering Ryan White Title II. An appropriate administrative percentage will also need to be specified when negotiating with the lead agency. An administrative budget should then be developed, either as part of the lead agency's budget or separately.

Acceptable percentages for administrative costs may vary with the age of the consortium. Higher administrative costs may be necessary early on as the consortium conducts needs assessments, develops a service delivery network and builds membership.

Acceptable percentages also vary depending on how administration is defined. A narrow definition that focuses on processing and payment of invoices will require less than a broader definition encompassing program development, provider relations and quality assurance. Generally, administrative costs vary between 10 and 25 percent of the consortium's total budget.

# CHAPTER THREE

3

# 3. Organizational Options

This chapter explores some significant organizational questions that a consortium must address early in its development. States often define many aspects of consortium organizational structure, and the state Title II grantee should always be consulted prior to making organizational decisions. Decisions about organizational structure should be revisited periodically as the consortium grows and matures.

### Will the consortium function as a grassroots community organization or a nonprofit corporation?

A grassroots organization relies on its full membership to meet regularly and—although considerable work may be done in committees—to make all final decisions. By contrast, a consortium that models itself on a nonprofit organization (whether incorporated or not) typically elects a board of directors and delegates substantial decision-making authority to that board. The board meets regularly (usually at least monthly), the full membership less often (quarterly, bi-annually or even annually). Although both forms of organization can be found among Title II consortia, the nonprofit model appears to be favored, especially among regional and statewide consortia whose full membership cannot feasibly meet regularly.

### What are the responsibilities of board members?

Many consortia elect a board from the full membership to serve a leadership function. In consortia with boards, the board's main responsibilities are to

- formulate the mission statement with broad input from consortium members.
- hire and monitor the performance of the consortium coordinator or executive director.
- develop consortium policies.
- oversee a participatory strategic planning process.
- promote the consortium and increase its visibility in the community.
- oversee the work of committees and participate on committees.
- ensure fiscal solvency and accountability.
- assess the board's own performance.

*See Chapter 8 on Committees.*

### What are the roles of the full membership and the board in a consortium that has both?

Even in consortia that have delegated significant responsibilities to a board, there are several advantages to having the full membership meet on a regular basis. Meetings provide an opportunity for diverse members to solidify their commitment to the issues of HIV/AIDS, to increase ownership in both the issues and

the work of the consortium and to network with others who share common interests. The membership

- participates in formal and informal needs assessments.
- elects the board.
- participates on committees and working groups.
- publicizes the work of the consortium in the larger community.

**THE FOLLOWING POINTS SHOULD BE CONSIDERED WHEN ANALYZING THE ADVANTAGES AND DISADVANTAGES OF INCORPORATION:**

- The impact of incorporation on the consortium's mission
- Whether incorporation will enhance the consortium's role in the community
- Whether incorporation will result in a duplication of efforts currently under way in the community
- Whether establishing another nonprofit organization will be perceived as competing with existing organizations and their fundraising efforts, or as adding another layer of bureaucracy to fundraising and service delivery
- The willingness of members to assume the legal responsibilities and liabilities of incorporation
- Commitment to fundraising to cover the additional costs of the incorporation process, agency liability insurance, directors and officers' insurance, administrative overhead costs and personnel costs
- The ability and availability of a lead agency to substitute for incorporation
- Whether county and state employees are allowed to participate in community-based nonprofit organizations
- The willingness of the lead agency to share with the consortium the funds it raises

### Should the consortium incorporate?

Most states cannot contract with an unincorporated entity to handle state-administered funds. Consequently, most consortia must either incorporate or enter into an agreement with an incorporated organization to serve as its lead or fiscal agency. The decision to incorporate or use a lead agency is a complicated one that may be reconsidered at several points in the consortium development.

Most Title II consortia are not incorporated. The organizational dynamics of some consortia, however, have militated for incorporation and registration as nonprofit organizations. The reasons most often cited when consortia incorporate are enhanced possibilities for fundraising and unacceptable conflict of interest between the lead agency and the consortium. Conflict-of-interest issues may arise when representatives of the lead agency take leadership roles in the consortium, especially if the agency is also a primary service provider under contract to the consortium. Incorporation may or may not resolve such issues in the relationship with a lead agency.

Consortia interested in incorporating should consult a local attorney. Because of the unique nature of Ryan White Title II consortia—especially with regard to membership—each consortium

should investigate all types of nonprofit incorporation established by the state to find the incorporation status that best suits its needs.

### What are the advantages and disadvantages of incorporation?

#### ADVANTAGES

- Incorporation as a 501(c)3 allows consortia to solicit other sources of funding. Foundation grants and major donor programs require their recipients to have nonprofit tax status. If the consortium wishes to raise additional funds, incorporation is very likely to be required.
- Contributions made to a 501(c)3 consortium by its members or the general public are tax-deductible.
- As an incorporated nonprofit, the consortium can take advantage of reduced postal rates.
- If a consortium wants to assume fiduciary responsibility for all of its funds and to contract directly with the state, incorporation is required.
- Incorporation may be desirable in areas with very few service providers, where the fiscal agency is also the primary service provider for the consortium. Incorporating as a separate entity could reduce the potential for conflict of interest.
- Incorporation may eliminate or limit the liability of the fiscal agency, by allowing the consortium to assume fiduciary responsibility and liability for all funds it receives.
- As an incorporated entity, the consortium can directly hire staff.

#### DISADVANTAGES

- Consortium members (especially the board of directors) must assume fiduciary responsibility for all funds received and expended.
- Incorporation can create another level of complexity and responsibility, which a volunteer-based organization may not be prepared to handle.
- An incorporated entity incurs additional costs for such overhead operations as administrative support staff and benefits.
- Creating another nonprofit organization may be perceived by the community as another level of bureaucracy.
- A new organization may be seen by established organizations as competing for funds.
- Incorporation may limit certain lobbying and advocacy activities.

### What is a 501(c)3 organization?

These are organizations described by Section 501(c)3 of the United States tax code: religious, charitable and educational groups, health and social-service organizations, private foundations and private schools. The principal benefits of 501(c)3 status are exemption from federal corporate and income taxes and the ability to solicit tax-deductible contributions. Because 26 separate sections of the IRS code provide for nonprofit organizations to claim exemption from federal income taxes, consortia should consult legal counsel when exploring the benefits and disadvantages of incorporation.

### Should a consortium use a lead agency?

Most consortia rely on existing incorporated entities to administer funds and perform other administrative functions for the consortium. Lead agencies can take on many tasks, including organizing and staffing meetings, producing mailings, issuing requests for proposals and resulting contracts, reimbursing providers and producing reports. Often they provide substantial support for the functions of a consortium, such as conducting needs assessments. In some consortia the lead agency's role may be limited to, for example, receiving and distributing funds.

Sometimes the lead agency and consortium are almost indistinguishable, sharing boards, staff and space. There may be benefits to the consortium in such an arrangement, because the lead agency may contribute more in space, staff and in-kind services than it is reimbursed for. There may also be disadvantages. The consortium may not have a clear identity in the community or may be perceived to be controlled by the lead agency. Both perceptions can lead to difficulties in recruiting broad-based membership and community support.

Sometimes the lead agency is also a service provider for the consortium. This is where most difficulties arise, because of real or perceived conflict of interest (see Chapter 10). On the other hand, lead agencies that are also providers bring a great deal of expertise about HIV to their role.

Many types of nonprofit and community-based organizations have functioned effectively as lead agencies. Three popular types are AIDS services organizations, public health departments and local United Ways. Each type has advantages and disadvantages.

Clearly, there are advantages and disadvantages associated with any organization that functions as a lead agency. Each community will need to choose the configuration that best meets its needs. The choice is based on local resources, economic and political realities and the availability and willingness of area agencies to serve in this capacity. Whatever the decision, the responsibilities and expectations of the lead agency should be clearly stated in a written contract or memorandum of understand-

## Reported Advantages & Disadvantages of Different Lead Agencies

### Advantages of an ASO as the lead agency:

- experience with and commitment to HIV service delivery.
- close ties with the client population.
- more extensive fiscal-management and contract-monitoring experience than newer grassroots or community-based organizations.
- typically less bureaucracy than hospitals and health departments.
- experience with fundraising and grantwriting that can help the consortium develop new sources of revenue.

### Disadvantages:

- conflict of interest.
- public confusion about the respective roles and responsibilities of the consortium and the ASO.
- limited time to devote to service coordination.
- lack of service coordination and cooperation in the interest of maintaining a competitive advantage.

### Advantages of a Health Department as the lead agency:

- experience in prevention, and sometimes primary care services, for PLWA.
- access to clinical staff.
- access to other state and local funds.
- provision of considerable in-kind support for the consortium.
- clear distinction between the roles of the health department and the consortium.
- capacity to take on additional roles and responsibilities.

### Disadvantages:

- few direct ties to the client population, making for less responsiveness.
- distrust and lack of confidence on the part of the community.
- bureaucratic and cumbersome fiscal systems and requirements.
- politically-based disagreements between the health department and the consortium on policies and goals.
- difficulty introducing innovative approaches to health service delivery.
- difficulty generating additional dollars.
- accountability to city or county government, putting the lead agency in the position of serving two masters and pleasing none.

### Advantages of United Way as the lead agency:

- a history of service and planning to address health and social issues, often including HIV/AIDS.
- expertise in community organizing and volunteer management.
- experience with fundraising, fiscal management and accountability.
- an image of respectability that enhances the consortium's credibility.

### Disadvantages:

- community confusion about fundraising. Why give to the consortium if we already give to the United Way?
- alienation. Some United Way agencies consider their involvement with the consortium to fulfill their responsibility to PLWA, and thus limit further services.

ing and in the consortium's policies-and-procedures manual, so that all parties operate as informed participants.

### What are the minimum requirements for a lead agency?

At a minimum, the lead agency should meet the standards and requirements for financial-management systems and non-federal audits set forth or referenced in the **Code of Federal Regulations**, Title 45, Part 74, Subpart H; and Title 45, Part 92, Subpart C. In brief, these sections require demonstrated experience with generally accepted accounting principles, as evidenced by audit reports, appropriate records and financial management-information systems.

States may impose additional requirements. California requires fiscal agents to have a track record in program management, human service delivery, contracting for service delivery and sufficient cash reserves for 60-90 days of consortium service delivery.

### What are the lead agency's roles and responsibilities as they pertain to the consortium?

The consortium and its lead agency should clearly define their respective responsibilities. Clarity about their relationship will make for a healthier working relationship and prevent problems and misunderstanding. The consortium must also define how the lead agency will be compensated for its services.

The consortium's officers, executive committee or legal counsel, or the lead agency itself, may assume responsibility for writing a contract, agreement, letter of understanding or memorandum of understanding delineating the roles and responsibilities of the consortium and the lead agency. A sample memorandum of understanding appears as Appendix B.

Any or all of the following duties may be assigned to the lead agency in a written agreement:

- Signing subcontracts on behalf of the consortium
- Signing a contract with the state on behalf of the consortium
- Receiving invoices from subcontractors
- Invoicing the state for services performed
- Reimbursing subcontractors with funds received from the state
- Submitting regular programmatic and financial reports to the consortium and the state
- Employing, supervising and providing office space for consortium staff
- Maintaining consortium files
- Organizing consortium mailings
- Monitoring subcontractors

The consortium should regularly evaluate the performance of the lead agency. Clear criteria for evaluation should be spelled out in the memorandum of understanding between the two. The evaluation may take the form of (1) informal assessment of regular reports to the consortium by the lead agency, (2) an evaluation process developed and implemented by a consortium committee, (3) a questionnaire or report card filled out by consortium members or (4) a performance evaluation by a committee of financial experts not affiliated with the consortium.

### Should staff or board members of the lead agency serve as consortium officers?

Accepted financial procedures require a clear separation between the person who authorizes a payment, the person who writes the check and the person who keeps the financial records. Separate authority for different financial actions needs to be established during the negotiation process with the lead agency. To maintain a true "check and balance" on finances, some consortia do not allow lead agency staff to serve as board members or officers. Some do not allow lead agency representatives to sit as voting members of the consortium. However, other consortia have relied on lead agency staff and board members to play significant leadership roles, including serving as board members and officers. The key issue is whether a particular person can distinguish his or her role in the consortium and in the lead agency and can act in the best interest of the consortium when serving on that board.

### Should the consortium employ staff?

Some consortia have chosen to hire staff for administrative and/or direct service functions while others rely on the staff of their lead agency to conduct administrative functions and contract with providers for the provision of services. The decision to employ staff should be made carefully. A consortium must have an adequate cash flow to provide salaries, fringe benefits and operating expenses such as telephone, postage, space and travel. The consortium must also have an infrastructure to support staff recruitment, supervision, training, support and quality assurance.

Consortia are more likely to employ administrative staff than service delivery staff. A consortium that employs its own administrative staff guarantees itself someone whose time is dedicated to its needs, and is not reliant solely on the time of volunteers or in-kind staff on loan from a lead agency. Functions that may be assigned to administrative staff include development of the service delivery system, contract management, board and committee support and public relations.

There are, however, disadvantages to hiring administrative staff beyond cost. Once staff is hired, consortium members may feel that all the work of the consortium can be handed over to the staff. Members may resist taking on such important functions as recruiting new

members, raising funds and developing service delivery resources. Because the functions of consortia are numerous and complex, members must continue to play an active role in the consortium even when staff are hired. Consortia that do hire administrative staff often find it difficult to recruit and even more difficult to retain qualified staff due to the extensive demands of such jobs and limited ability to pay competitive salaries.

Some consortia employ staff to provide direct services, primarily for case management. This typically occurs in areas where there are not enough providers to provide services to PLWA. While hiring service staff may be necessary to ensure access, other providers may perceive the consortium as a competitor and thus be less willing to participate in the consortium. Also, the provision of services requires additional infrastructure and supervision to assure the quality, continuity and cost-effectiveness of services, which may increase administrative costs.

The following case studies illustrate three models of consortium organizational structure:

1. the consortium as an advisory body functioning through a lead agency (Massachusetts)
2. the consortium as a decision making body using a fiscal agent (California)
3. an incorporated, statewide consortium (Delaware)

### Advisory Consortium Using a Lead Agency: Example from Massachusetts

In Massachusetts consortia are unincorporated entities that function through lead agencies. Consortia have governing boards and most have bylaws. In addition to the governing board, all consortia in Massachusetts are required to have a Consumer Advisory Board (CAB) comprised of representatives of the infected population in the consortium service area. Representatives of the CAB comprise at least 25% of the consortium governing board.

Massachusetts consortia are advisory bodies which make decisions through the agreement of members and negotiation with the Title II grantee, the Massachusetts Department of Public Health (MDPH). The consortia undertake needs assessments and develop priorities for the use of Title II funds. Service providers collaborate with consortia members to develop applications for Title II funds and a unified application is submitted through the lead agency to the grantee (MDPH). The grantee reviews all applications and determines which services will be funded in each consortium and the funding levels, based on the information provided in the application and other information such as the course of the epidemic, results of program monitoring activities and the demonstrated ability of providers.

Consortia operating by this model may develop a range of collaborative programs that address the continuum of care, but cannot guarantee that these programs will actually receive Ryan White funding. Consortia may fundraise or apply for other grants (usually, but not always) through the lead agency. Consortia in Massachusetts have raised funds for prevention activities, community awareness forums, and education of school, fire and emergency personnel as well as HIV-related services.

The lead agency acts as the fiscal conduit and data coordinator for all agencies within the consortium receiving Title II funds. It receives a percentage of the consortium's total funding (average 11% across the state) to cover processing of vouchers and payments and performing other administrative duties. Some consortia hire staff through the lead agency, which also oversees the staff. With or without consortium staff, the lead agency is usually the convenor of the consortium. Increasingly, however, consortia chairpersons are selected who are not from the lead agency. Having staff from the lead agency also chair the consortium can be viewed as concentrating too much power in a single agency.

## Decision making Consortium Using a Lead Agency: Example from California

California has 42 consortia, three of which are incorporated and only one of which has satisfied the requirements to contract directly with the State Title II grantee. The rest use another organization as the "fiscal agent," California's label for the lead agency concept. The fiscal agent must satisfy several state-specified requirements such as

- be legally able to contract with the State (i.e. incorporated private or public agency).
- have a track record in human service delivery and program management.
- demonstrate compliance with generally accepted accounting principles.
- maintain sufficient cash reserves for 60-90 days of consortium service delivery.

Fiscal agents in California include United Ways, hospitals, community based organizations and health departments. In addition to contracting with the State on behalf of the consortia, fiscal agents generally assume responsibility for: (1) subcontracting with HIV service providers, (2) reimbursing subcontractors, (3) monitoring subcontractors (at least fiscal monitoring, programmatic monitoring may be done by the consortium), (4) invoicing the State, (5) employing management of staff and/or donating staff (the majority of consortia in California do not employ staff) and providing office space for staff, (6) convening meetings and (7) submitting financial reports to the State.

While the fiscal agent assumes fiduciary responsibility for a consortium's Title II funds, the consortium has responsibility for assuring a continuum of services for people with HIV/AIDS. Consortium activities include: (1) conducting needs assessments, (2) setting service priorities, (3) issuing and awarding RFPs for subcontracts, (4) developing service coordination plans, (5) monitoring the fiscal agent and subcontractors and (6) evaluating consortium processes and quality of services. Many get involved in other HIV-related activities in their communities including the CDC's prevention planning initiative.

Consortia in California are encouraged to have open, inclusive membership that is representative of the demographics of the community and the affected population. Other members are usually representatives of government agencies, community-based organizations, hospitals and other provider organizations Membership size ranges from 20 to 120, with most consortia outside of Title I areas ranging from 20 to 30 members. In general, consortium business is conducted by the full membership with larger consortia using executive committees for some decisions. Only the incorporated consortia have boards of directors. The significant majority of California consortia cover a single county, with the exception being six regional consortia.

### Incorporated Statewide Consortium: Example from Delaware

The State of Delaware has had a statewide consortium for Title II-funded services since the advent of the CARE Act. During the past year, the consortium has evolved in both its mission and structure to assume responsibility for the CDC prevention planning activities as well as Title II funds. The current stated mission of the consortium is "to facilitate and promote a statewide coordination and collaboration of organizations, groups and individuals who are developing, implementing and advocating services and policies toward prevention of HIV and the care of people and communities affected by HIV/AIDS in Delaware."

The Delaware HIV Consortium is incorporated as an independent, nonprofit organization. Membership is offered to both organizations and individuals. Currently there are 40 organizational and approximately 50 individual members. The structure of the consortium is based on five standing committees which feed into a 19-member board of directors. The standing committees are: (1) policy, (2) prevention, (3) treatment and services, (4) fundraising and (5) public relations. Ad hoc committees are formed as needed. Two currently active ad hoc committees are membership and allocation committees.

The consortium board is made up of the chairs or co-chairs from each of the five standing committees with the balance of the 19 members drawn from the general membership of all committees. Most of the committees elect their chairs or co-chairs, who are in turn appointed to the board. In compliance with CDC regulations, however, one of the prevention committee co-chairs is an appointed health department representative and the other a community representative, elected by the community. There is considerable effort given to ensuring representation of various interests and areas of expertise, including those of the infected community. Board positions are set aside for government appointments, and the Director of the State's Division of Public Health serves as an ex-officio member.

The consortium has authority for both the CDC prevention and Title II service dollars received by the State. Committees are responsible for specific consortium tasks related to this funding. For example, the treatment and services committee conducts an annual service needs assessments, identifies service gaps and sets service priorities. The ad hoc allocations committee recommends dollar allocations by service category and specific provider funding following an RFP process. The prevention committee oversees the CDC community prevention planning initiative.

With the exception of the prevention committee, all committee work results in recommendations which must be approved by the board and the full membership. To comply with CDC guidelines, neither the board nor the full membership can override the decision of the prevention committee.

The Delaware HIV Consortium works in partnership with the Title II grantee, the state's Division of Public Health. However, the decision-making responsibility and authority rests in the consortium. The State believes this arrangement has led to improved access to services for people infected or at risk for HIV disease and cites significantly increased numbers of people served as a result of its work with the consortium.

# CHAPTER FOUR

# 4

# 4. Bylaws

## What are bylaws?

Bylaws are a set of internal rules that guide the management of an organization. They help the board of directors or leaders conduct the consortium's affairs according to the will of the membership. Oleck (1988) defines three primary purposes of bylaws:

1. Regulating the internal practices and procedures of the organization
2. Defining the relations, rights and duties of the members among themselves and in relation to the organization
3. Defining the powers, duties and limitations of trustees, directors, officers and other agents

## Are Title II Care consortia required to adopt bylaws?

The CARE Act contains no provisions about the operations of consortia.

Whether or not a consortium incorporates, it should adopt bylaws and written operating procedures that clearly address decision-making processes. If a consortium decides to incorporate, some states may require filing of bylaws with articles of incorporation.

## Why are bylaws needed?

Bylaws provide guidance for effective management of consortia. They define the officers' duties, membership requirements and a host of other details essential to smooth operation. Because bylaws are prepared, adopted and amended by the general membership, they help ensure that decision-making authority remains in the hands of the members. Once adopted, bylaws should be reviewed periodically to ensure that they reflect good management practice and the will of the membership.

## How are bylaws created?

Typically, an ad hoc committee of 3 to 7 people is appointed to write the bylaws. Since local laws and customs differ widely, consortium leaders should consult a knowledgeable local attorney for guidance in the creation of bylaws. A local United Way office or a national nonprofit assistance association like the Center for Nonprofit Management (or one of its local affiliates) can provide additional guidance and referral to a knowledgeable attorney.

Copies of the draft bylaws should be sent to all members of the consortium with a call to a meeting to discuss and vote on them. Generally, a majority vote is required to accept the proposed bylaws; approval by two-thirds of the membership is typically required to amend the bylaws.

## What do bylaws look like and what do they cover?

A typical set of bylaws is organized as a series of articles, further-subdivided into sections. At a minimum, the bylaws should define

1. the mission and objectives of the consortium.
2. the lead agency and its roles and responsibilities, if applicable.

3. the governing bodies of the consortium (board of directors, coordinating committees, consortium coordinator, etc.) and rules pertaining to them.
4. leadership positions (president, chairperson, etc.), executive and management committees, standing committees, task forces and other structural components of the consortium and rules pertaining to them.
5. the roles and responsibilities of the members of the consortium.
6. qualifications for membership and the processes of selection, appointment, resignation and termination of membership.
7. dues and fees, if applicable.
8. rules about meetings, attendance requirements and voting.
9. processes for adopting, changing and deleting bylaws.
10. mechanisms for addressing conflict-of-interest issues.
11. grievance procedures.

Bylaws will differ from one consortium to another, and will be influenced by local laws. Appendix C contains sample bylaws for use by the ad hoc bylaws committee and legal counsel. **These sample bylaws are provided for discussion only and do not represent recommendations.**

# CHAPTER FIVE

# 5

# 5. Policies and Procedures

In addition to bylaws, written policies and procedures should be developed and approved by the entire membership. Copies of the policies and procedures manual should be provided to all members. This chapter identifies the main topics and key questions to be discussed and decided on by the consortium membership. The locally determined answers to these questions can form the basis of the consortium's policies and procedures manual.

Changes to the policies and procedures manual will be proposed by members or committees throughout the life cycle of the consortium. Culling and distributing key decisions from minutes of committee and consortium meetings will facilitate updating of the policies and procedures manual.

### What does a typical policies and procedures manual include?

The policies and procedures manual should include

1. the mission statement.
2. bylaws.
3. the current strategic plan (strategies, tasks, timelines).
4. membership policies and procedures.
5. committee policies and procedures.
6. job descriptions for all officers, board members, committee members and general members.
7. copies of all contracts, letters of agreement and memoranda of understanding with the fiscal agency and subcontractors.
8. meeting rules and regulations.
9. confidentiality, policy including any sanctions for breaching confidentiality.
10. conflict-of-interest policies and procedures.
11. conflict-resolution policies, processes and procedures.
12. description of the fund-distribution process.
13. other policies and procedures pertinent to the consortium's role in the community.

---

**Key Points to Consider When Developing Policies and Procedures**

*Note: Not all points will apply to all consortia*

**GENERAL**

- The consortium's mission
- The consortium's responsibilities
- How the consortium's performance will be evaluated
- Conflict-of-interest policies and procedures
- Confidentiality policy

- Policies and processes that govern conflict resolution
- The consortium's definition of key terms referred to such as family, case management or emergency assistance
- Where records will be kept
- Who will be responsible for maintaining records

**LEAD AGENCY**

- Roles and responsibilities of the lead agency
- The contractual agreement between the consortium and the lead agency
- Who will negotiate the contract with the lead agency
- Relationship of the lead agency to the consortium
- The authority of the lead agency to act independently
- How the lead agency's performance will be evaluated

**FUND DISTRIBUTION**

- Procedure for distributing the consortium's funds
- How the availability of funds will be announced to potential service providers
- Guidelines or criteria for selecting service providers
- Appeals process for service providers who do not receive funding or have grievances about fund distribution

**SUBCONTRACTORS**

- Roles and responsibilities of subcontractors
- Standard documents for subcontractors
- Person(s) responsible for negotiating contracts
- Whether a quality-assurance or quality-improvement program will be required of subcontractors
- Case management and other service standards
- How subcontractors' performance will be evaluated
- Conditions and procedures for terminating a contract

**MEMBERSHIP**

- Number of members allowed
- Categories of membership
- Recruitment and selection process
- Voting rights of different categories of members
- Process for removing members
- Whether members will be required to sign a commitment statement
- Grievance or complaint process

**BOARD MEMBERS**

- Officer and/or board-member positions to be filled
- Selection process
- Roles and responsibilities of each officer and board member
- Authority assigned to each
- Process for removing officers and board members
- How officers' and board members' performance will be evaluated

## How will policies and procedures be enforced?

The consortium as a whole should agree on the ways in which its policies and procedures will be enforced; otherwise they become pointless. While one or two people may be assigned to monitor compliance, responsibility for assessing that everyone

"plays by the rules" rests with the collective membership. The consortium's culture or tone will be affected by whether or not its policies and procedures are enforced. Members should be encouraged to speak up if they believe that policies and procedures are being ignored. Either the policy or procedure needs to be reconsidered, or a new consensus needs to be reached about how to enforce its provisions.

*See Chapter 12 on Grievance Procedures.*

# CHAPTER SIX

# 6

# 6. MEMBERSHIP

The composition of the consortium's membership is a key factor in success. In general, membership should be inclusive and as diversely representative as possible of people infected and affected by HIV. Chapter 1 discusses specific types of people who should be actively recruited into the consortium. Both recruitment and retention of members pose an ongoing challenge for all consortia.

If there is a formula for membership recruitment and maintenance, it is this: the better organized and operated the consortium, the easier it is to recruit new members and to retain current members. Members will feel that they are making a worthy contribution to an effective enterprise if

- the consortium's mission is clearly defined.
- policies and procedures are documented and agreed on by all members.
- strategies and tasks necessary to the mission are specified and pursued by the members themselves.
- the committee structure is such that all participants understand their roles and responsibilities.
- meetings are conducted in a participatory, efficient and timely manner.

### Should there be a limit on the number of members recruited?

The intent of the CARE Act legislation is to place local decision making in the hands of a group broadly representative of everyone infected and affected by HIV. At the same time, however, the consortium has work to do, and it is hard to conduct productive meetings with hundreds of people present. Therefore, the demands of productivity must be weighed against the mandate of the legislation.

Consortia with large memberships typically assign the bulk of the work to smaller groups, such as a board of directors and committees, which report their activities to the full membership at semiannual or annual meetings. Consortia structured along these lines need to carefully delineate decision-making authority, spelling out in advance which decisions are made by the general members and which by the board of directors.

A decision to limit the number of members should not be made until inclusiveness and diversity have been achieved. The membership should include all perspectives on HIV in the community. In addition, venues and forums for regular communication between the larger community and the consortium should be in place.

### Should different types of membership be offered?

Theoretically, there are several types of membership that can be offered to individuals and agencies interested in participat-

ing in consortia. These include full voting membership; advisory nonvoting membership; and transitional membership for those in the process of fulfilling requirements for full membership and nonvoting membership. In practice, most consortia have two types of members, voting and nonvoting. The nonvoting members are usually staff or board members of a lead agency or contracted service provider. Assigning voting privileges to these members could constitute a conflict-of-interest issue.

When membership is not fully inclusive and representative of the infected population, a consortium can expand its scope of reference by soliciting input from nonmembers. Nonmembers can contribute needed expertise through participation on selected committees and in surveys and focus groups to identify needs and service gaps. Nonmember participation also has value as an avenue for member recruitment.

### How can the consortium ensure diversity among its leaders and members?

A membership plan is a useful way to track and analyze inclusiveness and diversity. The plan should define key occupational, geographic, demographic and social characteristics representative of the area and population served by the consortium, and the process by which members will be recruited. A membership plan should address

- **inclusiveness**, as represented by the different perspectives of

  1. consumers, including people living with HIV/AIDS and their families and significant others.
  2. community leaders, including neighborhood activists and representatives of the Chamber of Commerce, United Way and the like.
  3. community-based organizations, including those serving various ethnic communities, those addressing health issues such as sickle-cell anemia and community-action agencies.
  4. gay and lesbian organizations.
  5. AIDS services organizations.
  6. medical providers, including hospitals, health departments, private medical and dental groups, medical societies, primary care clinics, community and migrant health centers, home health agencies, hospices and nursing associations.
  7. mental health providers, including mental health clinics, crisis centers, substance abuse treatment programs and private counselors.
  8. social and support service providers, including social service

departments, adoption agencies, food banks and emergency-relief agencies.

9. housing providers, including housing authorities, long-term care facilities, homes for PLWA and homeless shelters.

10. programs that enhance access to care and treatment, including Medicaid, clinical trials, sexually transmitted disease clinics, and tuberculosis prevention/treatment services.

11. business people, including small business owners and executives of corporations.

12. educational institutions, including schools, colleges, technical schools and professional schools.

13. religious leaders, including rabbis, priests, ministers and others.

14. policy makers, including elected city, county and state officials.

15. law-enforcement and correctional officers, attorneys and judges.

16. the media, including advertising, print, radio, television and cable.

17. youth services, including runaway and homeless youth shelters, teen clinics, youth organizations and community centers.

18. women's services, including family planning, rape, and domestic violence programs.

- **diversity,** based on such population characteristics as

  1. geography (neighborhoods in urban areas and counties or communities in rural areas).

  2. gender, including transgender.

  3. sexual orientation, including homosexual and bisexual males and females.

  4. ethnocultural background, including the various ethnic and cultural communities within the catchment area.

  5. risk for HIV, including injection drug users and persons with hemophilia.

  6. physical disability, including hearing-impaired and sight-impaired people and others.

- **a process** for recruitment and selection, including

  1. how prospective members will be identified and nominated.

  2. how people will be contacted.

  3. who is responsible for contact and follow-up.

  4. how the consortium will track who is being recruited and how invitations to join will be issued.

## Sample Consortium Membership Roster for Tehema County (California)
## Consortium: Small Rural Consortium

| ORGANIZATION/AFFILIATION/PLWA | PERSPECTIVE(S) |
|---|---|
| Home Care Agency | In-home caregiver for person with HIV |
| PLWA | HIV infected |
| Family member of person with AIDS | Educator of children |
| PLWA | HIV infected |
| Counselor | Recovering substance user addict and teen facilitator for abuse, date rape and domestic violence |
| Parent of HIV positive son | Intake worker for welfare |
| Parent of Hiv positive daughter | |
| Home Health Care Management | Health care provider |
| California Health Professionals, Inc | Health care provider |
| Family Service Agency | Mental health outpatient-psychotherapy provider |
| St. Elizabeth Community Hospital | Fiscal agent: nonprofit community-based hospital representative |
| Gay male | |
| Tehema County Head Start Family Service | Private nonprofit community-based provider serving low income families including minorities |
| Parent of a son who died from AIDS | volunteer for probation department |
| PLWA | HIV peer educator |
| Concerned citizen | Board member of 3 volunteer organizations |
| Migrant educator | Bilingual bicultural |
| Ex-substance user | Family member of PWA deceased low income |
| Tehema County Health Agency, Public Health Nursing | Public health designee for TB control, AIDS Program Coordinator for HIV testing and surveillance |
| St. Elizabeth Home Health Hospice | Nonprofit community-based organization service provider to ethnic minorities |
| Home for Hispanic Women | New immigrant and minority advocate service provider for women |
| Tehema County Health Agency | Tehema County Health Agency |
| Tehema Recovery Center | Drug alcohol counselor works with low-income, homeless and dual-diagnosed clients |
| Tehema Recovery Center | Community-based nonprofit residential drug/alcohol treatment center serving minorities homeless, dual-diagnosed |
| North Valley Indian Health Program | Community health representative for Native Americans |

Recruitment of a diverse and inclusive membership is a challenge for consortia, and recruitment of diverse representation from the infected population is particularly challenging. All perspectives may not be represented at all times, particularly in the early stages of development. However, consortia should analyze and acknowledge significant gaps in representation and move systematically to fill these gaps.

### What points should be considered before recruiting new members?

Before embarking on a recruitment plan, the consortium should review its internal procedures and policies to answer the question: Will new members feel welcome? Changes in the time, place or format of the meetings, or expanded member orientation, may enhance the appeal of membership.

### How can the consortium attract potential members?

The best way to "sell" a potential member on the importance of the consortium's work is for someone with a prior personal connection to meet with him or her. The recruiter should

- explain the mission and goals of the consortium.
- connect on a personal level by explaining why he or she joined the consortium.
- describe why the potential member is needed and the specific contribution he or she can make.
- candidly estimate the time commitment.
- be clear about what is expected (for example, participation on a committee or attendance at meetings).
- explain the membership-selection process.
- give the recruit time to consider.
- follow up with a telephone call to assess the candidate's interest.

The most difficult people to recruit are usually those at the top of the power structure (heads of agencies) and those at the bottom (the disenfranchised, such as the homeless). To reach both groups, it is crucial to delegate a recruiter whom the potential member already knows, and for the recruiter to arrange a face-to-face meeting.

Consortia should not rely on their own staff or lead agency staff to recruit members. Staff have many other responsibilities and cannot allocate enough time to recruitment efforts. Moreover, members often have a closer personal connection to potential new members.

### What steps should be taken to orient new members?

Thorough orientation before the first meeting will help new members "get up to speed" and feel prepared and welcomed.

New members should be sent an orientation packet consisting of a fact sheet or

overview of the Ryan White CARE program, a brief history and the mission statement of the consortium, bylaws, a list of services provided, a list of regular and board members (with addresses and phone numbers), a list of committees and their members, the current year's work plan, the past year's minutes, member and committee job descriptions and other pertinent information. The orientation packet should be compiled or adapted as necessary to accommodate the language preferences and literacy levels of new members.

The orientation can be conducted by members or staff. Responsibility for compiling and updating orientation materials can be delegated to a committee, individual volunteers or staff. A buddy system that pairs new members with someone who can "show them the ropes" can be very effective.

There should also be a procedure for introducing and welcoming new members into the consortium. Attending a full-membership meeting for the first time can be overwhelming and confusing, especially if there is no mechanism to acknowledge and integrate new members.

### What is expected of members?

Members usually join the consortium with a pre-existing level of commitment to effective and inclusive services for people living with AIDS. Most participate as volunteers. The consortium can stimulate and build on member interest by clearly defining its mission, goals, responsibilities and procedures. In return, the consortium can expect from its members

- agreement with the mission statement.
- representation of targeted populations and/or representation of targeted agencies.
- participation in a certain number of meetings per year.
- participation on a committee.
- participation in planning retreats and special projects.
- adherence to consortium bylaws and policies and procedures.
- formal commitment indicated by signing a letter of agreement.

Additional responsibilities, such as assistance in fundraising activities, may be specified in member job descriptions. Some members may not be able to fulfill all expected functions; consortium policies and procedures should acknowledge that not all members are expected to do everything. Consortium leaders should negotiate with members the activities they are interested in and able to fulfill.

Nonmembers serving on consortium committees or participating in activities should also be expected to adhere to policies and procedures, especially those pertaining to confidentiality and conflict of interest.

### What continuing education and training should be offered to members?

Continuing education and training opportunities serve many functions. They promote constructive working relationships among consortium members, reward members for their time and effort, develop members' knowledge and skills related to HIV and organizational functioning and advance the work of the consortium. Consortia have found the following educational opportunities useful for their membership:

- Strategic planning retreats
- Trust-building and team-building workshops
- Conflict-resolution workshops
- HIV/AIDS informational sessions
- Workshops on roles and responsibilities of board members

### How can the consortium facilitate the recruitment, orientation and effective participation of people living with HIV/AIDS?

It is vitally important to involve people living with HIV/AIDS if the consortium's programs are to be truly responsive to their needs. People living with AIDS can play a particularly invaluable role in

- needs assessment,
- program planning,
- priority-setting and allocation of funds,
- monitoring funded programs,
- evaluating the effectiveness of the consortium and the programs it funds,
- reality checks, keeping the consortium "honest", focused and on target.

In 1994, HRSA funded an evaluation project entitled *The Participation of People with HIV in Title I HIV Health Service Planning Councils*. This report identified key factors that promote the full participation of people with AIDS and HIV in the planning and decision making of CARE Act Title I Planning Councils. The project also examined methods of eliciting feedback from the consumer population in the absence of full participation in meetings. Many of its findings are applicable to Title II consortia.

In the HRSA study, the main obstacles to participation were illness; the commitment of time, resources and energy required; lack of language translation; discomfort with the process; and competing priorities. Some people living with HIV/AIDS also feared that public disclosure of their HIV status would provoke discrimination and stigmatization.

The following steps are recommended to overcome these obstacles to involvement on the part of people living with AIDS. They also facilitate the participation of other community members.

1. Define, implement and publicize a member-recruitment policy that

includes proactive efforts to recruit people infected with HIV.

2. Establish a membership committee with responsibility for implementing the member-recruitment policy.
3. Clarify and make known whether HIV-positive individuals must publicly disclose their HIV status in order to become members.
4. Specify and make known the support services (such as mentoring and reimbursement of expenses) that could facilitate participation.
5. Consider specifying a minimum percentage of PLWA in the general membership and on various committees. In December 1994, DHS issued a policy paper entitled *Participation of People with HIV in Title I HIV Health Services Planning Councils*, which specified that a minimum of 25 percent of the membership of planning councils should consist of people living with HIV.
6. Allow for rotating participation by HIV-positive members or proxy voting.
7. Build in flexibility regarding members' time commitments, attendance and assignments to tasks in recognition of fluctuating health status.
8. Provide reimbursement for transportation, parking and child-care expenses incurred while attending meetings.
9. Provide nutritious free meals and beverages at meetings and other activities.
10. Rotate the locations and times of meetings if doing so would accommodate the special needs of people with compromised health.
11. Acknowledge continuing discrimination issues and address them in consortium activities and programs.
12. Develop mechanisms other than membership for eliciting input from infected individuals—for example, town meetings and speak-outs, surveys, interviews, hearings, subcommittees, canvassing HIV-positive individuals at points of service delivery and focus-group discussions.
13. Build a shared expectation that all members have responsibility for obtaining input from and providing feedback to HIV-positive nonmembers.

### What initiatives help sustain member commitment?

Sustaining commitment and enthusiasm for the consortium is challenging. All organizations experience an ebb and flow of involvement and interest. Thus it is important to bring in new members on an ongoing basis. They infuse the consortium with new energy and fresh perspectives. It is also important to rejuvenate existing members. Methods to sustain member commitment include the following:

- Acknowledge people for their contributions and give them positive feedback on an ongoing basis by thanking them at meetings, honoring

them at special events, developing an awards program or featuring them in newspaper or newsletter articles about the consortium. Celebrate the accomplishments of the consortium at an annual social event.

- Provide opportunities for continuing education, training, leadership development and other growth-promoting activities.

- Effective meetings also help to keep members involved. Start by mailing out an agenda and a packet of background information needed for decision making at least one week before the meeting. Specify when the meeting will begin and end, and start and adjourn on time. The meeting facilitator or leader should ensure that discussion does not stray from the agenda, and that the discussion leads to an agreed-upon course of action on all items that require decisions.

- Consider scheduling time for optional socializing and networking immediately before or after the meeting. For some people, these opportunities represent a critical reason to remain involved.

### How can members be removed?

Once criteria for membership have been established, the consortium can adopt a process for removing members who no longer meet the criteria or who violate the bylaws, policies, procedures or rules of the consortium. To discourage attempts at removal based solely on personality conflict, the removal process must be fair and impartial. Members can only be removed fairly if there are clear membership requirements and clear rules. The recall policy should incorporate the following elements, drawn from standard organizational personnel policies:

1. **Written notification** to the member about the violation. This notice should specify actions necessary to correct the violation and the time frame within which corrective action must occur. It is typically written by the consortium's principal leader or his/her designee (e.g., the chair of the membership committee).
2. **A meeting to mediate a solution** between the member or members and the principal leader.
3. **Mediation and conflict resolution** facilitated by an outside expert. This action should be taken if the member refuses to pursue a solution with consortium leadership.
4. **A motion to remove** the member if all attempts at mediation fail. The motion should be introduced to the membership committee or the full membership, with complete written documentation of all prior steps taken. Removal usually requires a two-thirds vote of the members.

# CHAPTER SEVEN

7

# 7. LEADERSHIP

In "Consortium Approaches to the Delivery of HIV Services under the Ryan White CARE Act," McKinney (1993) points out that few members are able to take on leadership roles due to time constraints, multiple committee assignments and lack of employer support for consortium participation. The demands of leading a volunteer initiative are heavy—but they are also personally rewarding and professionally valuable.

This section describes the attributes that the consortium should expect from its leaders. It also identifies steps that the consortium can take to ensure continuity of leadership.

### What constitutes consortium leadership and what should the consortium expect from its leaders?

Consortium leadership typically includes some combination of the following: a chairperson, co-chairpersons or a president; the officers or executive committee; a board of directors, a steering committee and committee chairpersons. The consortium should spell out each leader's roles and responsibilities—such as serving as a spokesperson or liaison with other organizations—and any limitations on authority, such as terms of office.

In the course of fulfilling their responsibilities and pursuing the consortium's goals, good leaders typically

- consult with consortium members on items for meeting agendas.
- chair consortium meetings, allowing for adequate discussion of all issues while keeping the meeting moving.
- supervise standing-committee chairpersons.
- represent the consortium in important matters that affect it.
- prepare consortium members to assume future leadership roles.
- enhance the consortium's image in the community.
- serve as a role model when representing the consortium.

When asked what attributes are important in leaders, consortium members mention thorough knowledge of HIV issues and gaps in service, good interpersonal and problem-solving skills, ability to use members' time effectively and skills in facilitating discussions while leading the group toward consensus. The personal attributes valued most are an "inspiring" personality, a reputation for being fair and unbiased and a sense of humor.

Consortia must be careful not to overwork their leaders. All members should help perform consortium tasks, even when outstanding leadership is in place.

### How are consortium leaders selected?

The process of selecting leaders varies from consortium to consortium. Among the most common methods are nomination and majority vote by the entire member-

ship, nomination or election by committee, selection by committee chairs, appointment by committees or groups representing local communities or counties and combinations of the above methods.

A consortium may stipulate that members must participate actively in the consortium for a period of time—such as one year—prior to serving in the leadership positions. This requirement helps assure that potential leaders are familiar with the mission and procedures of the consortium and that members recognize the strengths potential leaders bring to the consortium. If a consortium targets particular individuals and positions for leadership development, the continuity of leaders will be ensured.

### How can the consortium ensure that new leaders are prepared to lead effectively and in keeping with the consortium's goals?

To ensure a continuum of good leadership, consortia should treat leadership development as an ongoing activity. The following policies and procedures should be considered:

- Consider creating management teams of two or three people with different strengths. This strategy allows for clearer delineation of responsibilities and more reasonable time commitments.
- Encourage emerging leaders to serve as chairpersons of committees or task forces. Delegate responsibilities to them and convey the benefits and recognition that accompany leadership.
- Create incentives to assume leadership roles by negotiating with prospective leaders' employers to grant release time as an in-kind contribution.
- Promote internal communication. Share managerial reports with chairpersons and other emerging leaders throughout their tenure as volunteers.
- Limit officer nominations to individuals who have served actively on a committee for at least one year. This policy will familiarize emerging leaders with the consortium's operations, and in turn will allow the membership to get to know their philosophies and management styles.
- Consider a leadership structure that designates the vice-president as president-elect and the immediate past president as chair of the nominating committee.
- Arrange for new officers and chairpersons to be oriented at a transitional meeting with their predecessors.
- Maintain complete and organized records to facilitate the transfer of

historically significant knowledge. These files should include bylaws, job descriptions, assessments of goals and objectives, project reports, annual reports, meeting minutes, financial records and mailing lists.

- Encourage leaders and members to attend workshops on communications, conflict management, problem solving and decision making.

*See Appendix C for a sample of how leadership roles and responsibilities may be addressed in the consortium's bylaws.*

# CHAPTER EIGHT

8

# 8. COMMITTEES

## Why should the consortium have committees?

Committees are appointed, elected or drafted for a purpose. They have defined assignments to complete within a specified time. Committees help accomplish the business of the consortium more effectively and efficiently than if all discussion, background work and development were undertaken by the full membership. Committees can do a great deal of preliminary work with fewer people and report their recommendations back to the consortium for final decisions.

According to *Policy and Procedure Manual for Governing Board Members* (US DHEW, 1978), committees are useful because they

- distribute the workload so that a few people need not carry the entire burden.
- provide opportunities to participate and contribute to the mission of the group.
- elicit group-generated ideas, which are usually better than the ideas of a single individual.
- provide an orderly method of planning and carrying out the work of the organization.
- allow individuals to develop their leadership capabilities and skills.

Title II consortia have very specific tasks, and committees are frequently the most efficient way to accomplish these tasks. Each consortium must assess what it wants to accomplish and designate committees that will pursue the completion of the necessary tasks. To promote effective committee work, the purposes of every committee should be clearly defined. The consortium should define the broad purpose of each committee, its powers and responsibilities and its duties. The committee should then develop its own strategies for pursuing its mission, tasks and timelines.

The consortium is also responsible for defining the scope and limits of the committee's authority, and the time span for which it is appointed. The consortium as a whole must decide how much authority is invested in a committee and then resist the temptation to 'redo' the committee's work by rediscussing every aspect of its recommendation.

Committees work in a number of ways. At meetings, the members plan jointly; they all take part in committee discussions and decisions. However, the preliminary work may be allocated to individuals, subcommittees, teams or pairs or combinations of these configurations during or between meetings. It is not necessary for the entire committee to write a request for proposals, report or letter. Individuals or teams may compose questionnaires, conduct surveys, compile and analyze data, make telephone calls or draft policies and procedures.

## Which committees are necessary?

Two basic kinds of committees are used by consortia: standing committees and special or ad hoc committees. A standing committee has a continuing function, while an ad hoc committee comes into being when the need arises and disbands upon completion of its work.

### STANDING COMMITTEES

***Note: The following standing committees have been deemed essential by many consortia. The functions described below could be conducted under other names or combined:***

**Executive.** Usually composed of officers and chairs of other committees. Provides leadership, consortium oversight and committee oversight and can exercise varying degrees of decision-making authority. The executive committee usually meets between general-membership meetings and may be authorized to act on behalf of the consortium in the intervals between consortium meetings.

**Finance.** Oversees management of funds and ensures that financial reports are prepared and distributed to consortium members

**Monitoring, Quality Assurance.** Oversees both the lead agency and subcontractors, and may develop quality-assurance and quality-improvement plans. Some consortia assign individual members of this committee to serve as liaisons to service providers The liaison conducts site visits, reports issues and problems to the consortium and maintains communications with the service providers

**Needs Assessment, Program Planning, Strategic Planning.** Develops a needs assessment plan and tool, and collects data about unmet needs on an ongoing basis Develops or provides support for short and long-term planning processes. Separate committees may be formed to address needs assessment and strategic planning, especially when these activities are intensive

**Client Services.** Responsible for drafting a service delivery plan and possibly for reviewing reports on client services.

**Public Relations, Networking, Communications.** Responsible for community networking and for placing public service announcements, newspaper articles and announcements of meeting dates. Members may attend meetings of other organizations to promote the consortium, and may develop a speakers' bureau.

**Grants or Fundraising.** Develops a fundraising plan and either directly implements the plan or convenes ad hoc subcommittees to perform different fundraising tasks.

**Provider Selection, RFP Review.** Develops criteria for selecting service providers, may write Requests for Proposals (RFP) or application instructions. Reviews proposals from prospective service providers and recommends selection to board or full membership.

**Nominating or Membership.** Develops a plan to recruit new members. Responsible for orientation of new members and, possibly, for mentoring and monitoring members.

**Policies and Procedures.** Drafts policies and procedures, updates and distributes the policies and procedures manual and may be responsible for parliamentary procedure during meetings.

**Personnel.** Develops and updates personnel policies. May assist in staff recruitment. May handle personnel grievances at the board or membership level.

**Legislative, Public Policy.** Monitors shifts in pertinent public policy. May work with consortium members on letter-writing campaigns, meetings with public officials and grass-roots advocacy.

**Evaluation.** Develops a process to evaluate the performance of the consortium, possibly drawing on peer-review techniques or external input.

## AD HOC COMMITTEES

***Note: Each consortium should decide which special committees it needs in light of local conditions. Consortia have established special committees to study and recommend action on the following pressing issues:***

- Outreach strategies
- Long-term care
- Housing programs
- Family support
- Durable medical equipment
- Services for pregnant women
- Appeals (usually convened as part of the fund-distribution process to handle service-provider appeals relating to applications for funding)
- Grievance (usually convened when a member files a grievance, to investigate, make recommendations to the full consortium or act as the final arbitrator)

Though most of the functions in the above lists will need to be addressed at some point in the life of the consortium, no single consortium is likely to need all of these committees. Many experts in organizational development argue for fewer rather than more committees. One option is to collapse several of these committees into a single committee with an expanded sphere of responsibility. Another is to designate certain committees as ad hoc rather than standing committees. For example, a new nominating committee could be established each year before elections to recruit new candidates for office. A third possibility is to have fewer committees but multiple subcommittees.

Some organizational-development experts advise reconsidering all committees at the beginning of each new year to counteract the tendency toward proliferation of committees. The consortium should evaluate what committees are likely to be needed, given the results of the needs assessment, strategic plan and anticipated workload for the upcoming year.

### What makes a committee successful?

After the consortium has defined the purpose of a committee and spelled out its responsibilities and duties, the committee decides on its own goals, objectives and timelines. Its work is more likely to meet with success if

- the committee holds meetings only when the task at hand is better suited to a group than an individual. There should be no unnecessary meetings.
- a committee chair is appointed by the board chair, the executive director or the committee itself. The committee chair should know—or be trained in—how to plan and follow an agenda, guide discussion, facilitate participation, resolve problems, summarize conclusions and specify actions to be taken.

- committee members understand the charge of the committee. The charge should be specific and in written form.

- committee members understand their role, which includes regularly attending meetings, reading background material before meetings and participating in discussions. They should all work to keep the committee focused, to reach decisions and to evaluate the committee's work.

- the committee members receive an agenda and background materials one week before each meeting. This communication should specify what is to be accomplished at the meeting so that members can be adequately prepared.

- the committee's activity is consistent with established program priorities and the overall objectives of the consortium.

- the committee focuses on implementation rather than merely brainstorming what needs to be done.

- the committee members represent a diversity of viewpoints. The committee should make constructive use of conflict, opposition and criticism. The contributions of all members should be valued.

- the committee occasionally invites nonmembers to attend meetings in order to broaden its perspective.

- consortium staff who attend committee meetings understand that their function is to provide data, help prepare agendas and analyze issues, alternatives and implications. Staff should understand that their role is not to manipulate or unduly influence the decisions of the committee.

- committee assignments are distributed among the members.

- meetings start and end on time. Committee members should feel that their time is used wisely.

- committee members feel that they are accountable to the rest of the consortium for their work and report regularly to the board or membership.

- the meeting place is accessible and comfortable.

### What are the characteristics of a good committee chair?

A good committee chair is committed to the consortium's goals and more devoted to the committee's job than to a personal agenda. An effective chair is able to inspire committee members to apply their abilities to performing the committee's work. He or she should know how to encourage and nurture all committee members and be supportive of their contributions. The committee chair should be knowledgeable about the subject of the

committee's work, and facilitate rather than dominate fulfillment of its charge.

### How should committee members be selected?

This decision will depend on the number and scope of people available to fill committees and on the decision-making process the consortium chooses. The most common options are (1) appointment by the full membership, (2) appointment by the leadership, (3) election by the full membership, (4) election by current committee members and (5) volunteer recruitment.

### What criteria should committee members meet?

Consortia whose work is performed by committee members need inspired and knowledgeable members who can devote time to participation. Effective committee members should demonstrate a commitment to service delivery for people living with HIV/AIDS and a willingness to focus on the consortium's goals and the committee's scope of work. Equally important are regular attendance and commitment to participating in the tasks of the committee. Finally, committee members need a cooperative spirit and sufficient knowledge to participate fully in the committee's deliberations.

Committee members do not need to be voting members of the consortium. Non-members can often provide valuable expertise about a specific consortium issue even though they might not have the time or commitment for full participation in the consortium. An accountant, attorney, media or business leader, for example, may be willing to serve on a committee. People living with HIV and AIDS, who may be unable to attend all consortium meetings, may also be willing to participate actively in committee work.

# CHAPTER NINE

9

# 9. External Relationships

If a consortium is to sustain its effectiveness over the long term, it must define, understand and nurture its relationships to other players in the HIV-care network.

### How should the consortium develop relationships with service providers receiving Ryan White funds?

To fulfill its legislative mandate to provide a comprehensive continuum of care, a consortium is dependent on the service providers in its area. Its best efforts should be expended on establishing, maintaining and strengthening relationships with these providers. The needs assessment and priority setting process provide the direction for development of a service delivery network.

Broadly speaking, development of the network breaks down into the following steps:

1. Look for a spectrum of providers to cover the full range of needed services.
2. Identify providers and agencies that are collectively equipped to provide services for people living with AIDS and the affected community.
3. Identify entities that receive state or federal funds for HIV-related activities, including Ryan White Title III(b) Early Intervention Programs, AIDS Education and Teaching Centers (AETC), maternal and pediatric programs funded by Ryan White Title IV, Special Projects of National Significance (SPNS) programs funded by Ryan White Title II, federally-funded community and migrant health centers, homeless health centers and housing programs supported with HUD Housing Opportunities for People with AIDS (HOPWA) funds.
4. Identify other providers and agencies already providing services to people with HIV/AIDS.
5. Identify community-based organizations (CBOs) that serve target populations for non-HIV-related health and social services.
6. Meet with service providers to explain the Ryan White Title II program, the mission of the consortium and the process of allocating service dollars. Encourage the service providers to become members of the consortium if appropriate. Find out the specific barriers they face in providing HIV/AIDS services.
7. Encourage the service provider to develop a service plan for HIV/AIDS. Provide assistance as needed.
8. Help service providers get the necessary training and other needed support to provide HIV/AIDS care. Support may involve developing standards of care, setting up administrative and billing systems or responding to an RFA.
9. Negotiate service contracts with service providers that clearly spell out performance expectations and terms of payment.
10. Monitor services to ensure that a) services are actually provided as specified, b) the quality of services

meets consortium standards, and c) the services are satisfactory to the clients and/or their caregivers or family members.

11. Give feedback to providers on a regular basis.
12. Pay providers promptly.
13. Recognize providers for their contributions.

### What are some strategies for bringing providers into the consortium's service network?

The difficulties of developing and maintaining a service network capable of providing a full continuum of care for people with HIV/AIDS are widely recognized by consortia. Lack of knowledge about the disease, limited access to specialists for consultation and referral, fear of being identified as "the AIDS provider" inadequate reimbursement and burnout are among the reasons cited by providers and organizations for not providing services. These problems are compounded in places where there is an overall shortage of health and social service providers.

Strategies to overcome reluctance to participate must be tailored to the reasons providers cite for not participating. For example, a provider whose main concern is inadequate reimbursement will not be enticed by educational opportunities to provide more services. Thus an essential early step is determining specific barriers to service provision. Some problems, such as inadequate reimbursement or a general shortage of primary care physicians, will only be solved over the long term, but creative approaches have been used to gain access to available resources. Some strategies that are frequently helpful are

- provision of educational opportunities, tailored to the needs and schedules of providers. AIDS Education and Training Centers (AETC) are specifically funded by HRSA to provide AIDS education throughout the country. Other federal programs, such as Area Health Education Centers (AHEC) and the Center for Mental Health Services (CMHS), offer training opportunities in some parts of the country. Some states have also established their own training and education initiatives. Consortia should not try to create their own training programs until they have exhausted the potential of these other resources.
- development of a formal system of consultation and referral to specialists. In some areas, existing informal systems of consultation and referral may suffice to give providers confidence in treating people with HIV/AIDS. In others, it may be necessary to develop more formal methods, such as "warm lines" giving less-experienced providers telephone access to AIDS experts, or periodic on-site visits and consultations.
- development of relationships with state and local professional societies and associations. If the leadership in a profession embraces the consortium's mission, its members will often follow.

Many consortia have been successful in presenting at medical society and other association meetings.

- a process for spreading responsibility among a group of providers so that no single provider is overwhelmed. Some areas have developed systems for rotating referral of patients among providers in a predetermined fashion. While such systems may alleviate providers' concerns about being overwhelmed, consortia must be respectful of clients' needs and preferences in any referral process.

**What is the consortium's relationship with other coalitions and planning councils?**

The most active members of the consortium will probably wear many hats and belong to a variety of related organizations, such as Title I planning councils, primary care associations, maternal and infant health task forces, gay and lesbian coalitions, the CDC prevention-planning task force, substance abuse task forces, health planning agencies and homeless coalitions. It is important for the consortium to have a visible and constructive presence in these other forums in order to promote its mission and services among an ever-growing number of alliances. These groups are in a position to refer clients to the consortium, to receive referrals from the consortium and to collaborate on projects such as conferences, interagency shared services and grant applications. Responsibility for participating in these groups should be shared among consortium staff and members.

**What is the consortium's relationship with groups not receiving Ryan White funding?**

Many groups are struggling with the same issues that challenge HIV care consortia. These issues include defining the mission and scope of work, membership recruitment, the development and implementation of productive boards and committees, decision-making issues, conflict management and interagency cooperation. The consortium in many ways has a symbiotic relationship with other groups. The consortium needs the local groups to serve as its eyes and ears in the community, while the local groups can benefit from the experience and skills of the consortium members.

Local groups that do not receive Ryan White funds are important links because they can provide

- a referral resource to facilitate access to services.
- input from and access to communities at high risk for HIV.
- essential information about the needs of people with HIV/AIDS in their communities.
- essential activities outside the scope of the consortium's mission, such as community education and local fundraising.

The consortium is in turn important to these groups because it facilitates communication, provides client referrals and can help clients access additional services and/or funding.

# CHAPTER TEN

## *Conflict of Interest*

10

# Conflict of Interest

By stipulating that the membership of consortia include individuals or organizational representatives with direct personal or professional expertise related to HIV services, Congress built the conflict of interest challenge into the legislation, and thus into the heart of state and local implementation of the Ryan White CARE Act.

—*Managing the Conflict of Interest Challenge*. Rockville, MD: US DHHS HRSA BHRD Division of HIV Services, 1992.

---

**What is a conflict of interest?**

Conflict of interest occurs when an appointed or voting member of a consortium has a direct or indirect fiduciary or other personal or professional interest in a consortium decision or the outcome of a vote. Conflict of interest also occurs when consortium members use their positions for purposes that are—or appear to be—motivated by pursuit of private gain for themselves or their families, friends or business associates.

Such conflicts may involve employment, contractual, creditor, personal or consultative relationships with organizations that have a direct or financial relationship with the consortium. Conflict of interest is often defined to include interests that existed within 12 months preceding the appointment to the consortium.

Often the mere perception of conflict of interest is a significant concern. The existence and wide availability of a written conflict-of-interest policy can help to increase awareness among members of the consortium of what does and does not constitute a conflict. Even when there is compliance with the policy, however, some situations that create the appearance of conflict may be harmful to the consortium. In general, it is advisable for consortia to strive constantly to eliminate any appearance of conflict of interest.

**How can a consortium ensure that its members adhere to a proper standard of conduct?**

Recipients of Ryan White funds are obliged to establish safeguards to prevent members and employees from using their positions for private gain. The consortium should also adopt and distribute written policies designed to prevent conflicts of interest. These rules of conduct should be given to all members, employees, contractors and subcontractors.

The guidelines should cover financial interests, gifts, gratuities and favors, nepotism and such related topics as political participation and bribery. They should be consistent with state and local law and should define "improper" outside activities, relationships and financial interests clearly. A process should be established for notifying consortium officers of questionable activities, relationships or financial interests, and in turn for notifying the violator of the violation and the penalty.

Administrative actions that may be taken include oral admonishment, written reprimand, reassignment, demotion, suspension and separation. Legal action may also be taken if warranted.

### How should a conflict of interest be handled?

A written description of what constitutes a conflict of interest should be included in the bylaws (see sample bylaws in Appendix C) and distributed to all consortium members. Conflict of interest should also be explained during new members' general orientation.

Voting members must sign a disclosure form (see the sample disclosure form in Appendix D) so that consortium leadership can excuse from voting any member who has a conflict of interest in a given decision. The consortium will need to decide whether those with a conflict of interest should also be asked to abstain from participating in discussion of the question at issue.

In cases in which a conflict of interest is found to have occurred, remedies may be pursued. For example, if a proposal-review process may have been adversely affected by someone with a conflict of interest, it may be necessary to reopen a particular proposal or set of proposals. If a person with a conflict of interest willfully violates or ignores the policy, it may be necessary to take action to limit his or her participation in certain consortium activities. In some states with strict conflict of interest laws, a person violating such laws may be subject to fines or other punishment.

If feasible, the consortium could establish a committee to review all conflict-of-interest matters. Alternatively, this responsibility could be undertaken by the Policies and Procedures Committee or the Executive Committee.

Participants in the Ryan White Title II Constituency Discussion Group Meeting convened by the Division of HIV Services in August 1993 suggested heading off potential conflicts of interest by separating the planning and priority-setting process from the provider selection and funding process, and by choosing people from outside the system to determine funding allocations. They also suggested making funding competitive and excluding from decision making those who have submitted applications or are closely affiliated with an applicant.

Finally, it is worth emphasizing that a diverse membership can militate against dominance of the consortium by service providers, whose decisions can too easily be self-serving. Broad-based membership, which includes community members and people living with HIV/AIDS, can balance discussion of service priorities and resource allocation. Appointing members for their expertise and not as representatives of a specific organization will not eliminate conflict of interest, but may help members clarify their role in the consortium.

## With the Best of Intentions: A Case Study on Conflict of Interest

Consortium X is a multi-county consortium located in a state which also has Title I EMAs. The area where the consortium is located is primarily industrial with one large urban center. Prior to the implementation of the CARE Act in 1991, one of the key AIDS service organizations in this area was Agency Y, which provided case management, AIDS information, provider referral, support groups and counseling services. Agency Y took the lead in convening the region's Title II Care Consortium when the CARE Act funding was received, as the local county health departments in the region had not shown any inclination or interest in HIV/AIDS program development. There was, in fact, a history of conflict between the community, as represented by Agency Y, and the health department in the county with the largest urban center. Agency Y was known statewide and was a strong advocate for people with HIV/AIDS in the legislature and with the state's Department of Health.

Consortium X's membership was initially composed of community members, consumers and volunteers/board members of Agency Y. County health department representatives, when they attended meetings, did not play a strong role in decisions during this initial period. Because of the very short timeline for getting services up-and-running in 1991, Agency Y was selected by the Consortium as the lead agency. Additionally, in the interest of expediting service provision, a "sole source" funding process was used to distribute the consortium's allocation. This resulted in the bulk of the consortium's allocation being awarded to Agency Y. Finally, because Agency Y was not only the lead agency but the primary funded service provider, the consortium elected Agency Y's executive director as the chair of the consortium.

After three years of operation, Agency Y is so entwined in the processes of Consortium X that it is difficult to determine where conflict of interest issues begin and end. Furthermore, the community served by Consortium X is beginning to object to what it sees as "domination" of the entire Title II process by Agency Y. There are several signs that the situation is deteriorating, including: (1) consumers are seeking services outside the consortium area because they are unhappy with the quality of service they receive at Agency Y but there is no alternative and no objective venue for client complaints, (2) the needs assessment completed by the consortium each year does not survey any key informants, providers or community members from outside the consortium sphere of influence and is not getting a true community-wide picture of needs, (3) membership on the consortium has dropped to a very small number of active members and (4) other community-based organizations serving minority communities, substance users, women and children are complaining at the state level about being excluded from the decision-making process.

Consortium X's intentions were to provide HIV/AIDS services in the most expeditious way possible. While they had the best intentions, the consortium's structure does not lend itself to full community participation and to meeting the changing needs of people with HIV/AIDS as the face of the epidemic changes. Additionally, Consortium X's structure does not have a process to guarantee the best possible quality of service.

Resolving the conflict of interest concerns in Consortium X may be accomplished by implementing the following policies and procedures: (1) the chair (leadership) of the consortium is not employed by any funded agency, (2) a clearly delineated Memorandum of Understanding between Consortium X and Agency Y relative to lead agency duties, roles and responsibilities is developed, (3) the consortium signs Letters of Understanding with all funded service providers—in addition to the signed contracts between the lead agency and the service providers, (4) the consortium mounts an aggressive membership campaign to recruit new members from the general community, affected/infected community, other service providers and other government agencies, (5) the consortium implements a focused plan to recruit other service providers to apply through the funding process and (6) the funding process is unbiased, objective and truly competitive with a selection committee composed of members who have no relationship to either the lead agency or any service providers applying for funds.

# CHAPTER ELEVEN

# 11

# 11. Conflict Management

### Is conflict inevitable?

Conflict is a natural part of life. Many of us have been socialized to feel that conflict is "bad" and to be avoided at all costs. But healthy and respectful conflict can enrich the consortium by contributing different perspectives and viewpoints. In a consortium that genuinely seeks diversity of background and opinion, conflicts are guaranteed to arise. By learning conflict-management skills, consortium members can promote an environment that encourages both cooperation and constructive conflict.

Existing consortia report that conflict arises most often over the following matters:

- where, when and how meetings are conducted.
- perceived and actual differences in values, interests and personal styles. Conflict arises over discrepancies in work output, commitment to service delivery and styles of expressing anger, frustration, discomfort, disagreement and the like. Differences in cultural backgrounds, sexual orientation, race and class give rise to conflict and misunderstanding.
- selection of service priorities.
- allocation of funds and choice of subcontractors.
- staffing decisions.
- client grievances.
- monitoring and evaluating provider organizations.

### How can conflicts be made productive?

Creating an atmosphere conducive to open and honest discussion and respectful of diverse viewpoints is the single best way to prevent conflicts from degenerating into destructive rivalries and power plays. This atmosphere requires that ground rules be established to promote effective communication during meetings. Useful ground rules include the following:

- One person speaks at a time; others listen and do not interrupt.
- Speak for yourself, using "I;" don't claim to speak for others.
- Be polite. It's acceptable to disagree, but do so respectfully. Insults and accusations are unacceptable.
- Observe confidentiality within established policies.
- Share group time fairly. Allow everyone a chance to speak and listen.
- Be open to listening to and learning from others' viewpoints.

Acknowledge frankly that differing points of view exist and that conflict is a natural part of the discussion process. Do not attempt to avoid conflict or sweep it under the carpet when it surfaces, but be careful to define the conflict. The more

specifically the problem is defined, the more suitable the solution is likely to be. It is also important for the group to distinguish between the issues and the individuals involved in the conflict.

Facilitate the expression of opposing views by providing ample opportunity for their advocates to speak and listen to each other. Encourage each party to restate the other's arguments to clarify any misinterpretations or misunderstanding, as a first step toward proposing alternative solutions and attempting to reach consensus. Understand that differences in culture, class, gender and personality influence how conflict is expressed. An effective chair can facilitate the process of negotiation and help reach a solution that allows all parties to feel they have gained from the process rather than that some people won and others lost.

A written policy describing the mechanism for addressing and resolving internal disagreements may help in situations that cannot be resolved at ordinary group meetings. Roberts' Rules of Order were originally developed to allow expression of differing viewpoints, and resolution of differences in an organized manner. They continue to be widely used because they have stood the test of time and because they work.

### What is mediation and when is it appropriate?

If conflict persists and the consortium leadership believes that continued discussions will be fruitless, an outside mediator may be called in. A mediator is a neutral, unbiased, nonpartisan third party experienced in conflict-resolution techniques. The mediator does not decide who is right and wrong, and does not tell the parties what to do. Instead, the mediator requires both parties to adhere to a systematic step-by-step process that often facilitates a consensus agreeable to both parties.

#### Robert's Rules of Order

In 1876, Henry Martin Robert, a former Union general in the Civil War, took on the task of codifying and simplifying the rules of procedure for the U.S. House of Representatives. In doing so, he drew on the workings of early English parliaments. Robert later adapted the rules to fit nonlegislative organizations.

The basic premise of Robert's Rules of Order is that rights must be respected: "rights of the majority, of the minority, of individuals, of absentees, and rights of all of these together."

The basic process is fourfold: (1) a member presents a proposal idea (a motion); (2) a second member expresses support for discussion of the idea by seconding the motion; (3) a discussion or a series of discussions is held to allow all opinions to surface and (4) a vote is taken on whether or not to adopt the motion.

### What is arbitration and when is it called for?

In arbitration, the conflicting parties agree to a formal hearing before a neutral arbitrator or panel. All parties make a binding agreement to honor the decision of the arbitrator. Arbitration involves an initial agreement to arbitrate, preparation of the case, a pre-hearing conference to

clarify procedures, a hearing, review of evidence and the decision. Arbitration services are available in most communities.

### What is adjudication and for what kinds of conflicts is it suitable?

Adjudication is a judicial process. Some conflicts that cannot be settled by mediation or arbitration can be pursued in administrative, civil or criminal courts of law. Consortia should resort to this form of conflict resolution only under the most extreme circumstances because of the personnel time, expense and calendar time needed to resolve differences through the court system.

*See Chapter 12 on Grievance Procedures.*

# CHAPTER TWELVE

# 12

# 12. Grievance Procedures

A grievance is an informal or formal expression of dissatisfaction with some aspect of implementation of the Ryan White CARE Act, or with the consortium's activities, that is brought to the attention of the consortium's leadership. A grievance procedure is a fair and systematic process that enables individuals or agencies to express dissatisfaction to a responsible and responsive group within the consortium and to obtain a fair and impartial assessment and a decision regarding the dissatisfaction.

Both informal and formal grievance procedures are evolving among consortia across the country. Informal methods include open forums, early-intervention procedures, hotlines for complaints, client surveys, patient-rights statements, patient advocates, case management and quality assurance reviews. These informal procedures can be time-saving and useful for building cooperative, congenial and satisfying relationships with consumers and members, because they employ methods that are proactive and amenable to early intervention. Formal methods include written grievance procedures and the use of outside mediators. These formal procedures can be useful because they define the grievance process and identify who will address complaints. A combination of informal and formal procedures can be employed by Ryan White Title II participants to maximize effective program management and service delivery.

Grievance procedures can address complaints that stem from three avenues: (1) client complaints about access to or quality of services, (2) consortium member complaints about processes or decisions and (3) agency appeals of funding decisions.

### What is the consortium's role in resolving a client's grievance?

Consortia that have incorporated as legal business entities and that provide direct client services must develop, document and make known a formal procedure for handling client grievances.

In most cases, the consortium is not a direct service provider and does not have direct contact with clients. In these cases, the consortium should avoid involvement in disputes between a service provider and its clients.

The consortium can, however, require the service providers it funds to define grievance procedures in their policies and procedures manuals and to ensure that clients are aware of and know how to pursue the procedures. At a minimum, the consortium can require its funded service providers to demonstrate a written client grievance and complaint process, client-satisfaction indicators, written personnel policies, adequate liability insurance and operation as a legal business entity.

The consortium can also inquire into the frequency of complaints registered by clients. These factors can be considered when evaluating a service provider's performance and when deciding which service providers to fund each year. In monitoring and overseeing its funded ser-

vice providers, the consortium is responsible for evaluating the quality of services it funds, and it can and should expect its funded service providers to meet certain standards of care.

The standards of care expected (and the measurement indicators) should be specified in the contract between the consortium or lead agency and the service provider. One standard of care should be client satisfaction; measurement indicators could be "number of client complaints" and/or "quality rating of specific services by clients." In sum, it is appropriate for the consortium to solicit feedback from clients about the quality of the services they are receiving. However, the consortium should not "micro-manage" its service providers. Resolving specific client grievances is the responsibility of the agency providing the services.

### What is the consortium's responsibility to a member with a grievance?

First of all, members' grievances should be confined to the consortium's areas of responsibilities. Members' grievances about meetings, membership, leadership selection and performance, committee staffing and performance, policies and procedures are appropriate to bring to the consortium.

Grievances about service providers' performance, clients' complaints, problems with state or local health departments and other matters outside the aegis of the consortium should be pursued elsewhere.

*See Chapter 11 on Conflict Management.*

### How can a consortium member express grievance or concern in a constructive manner?

There are many different ways to express a grievance. When a consortium provides its members a procedure for registering grievances and concerns, the process should involve the complainant and should include specifics about the processes, the people responsible for decision making, the timeline for each step and the appeals process. Informal methods to resolve differences should be explored prior to initiating a formal complaint. A typical grievance or complaint process includes the following steps:

1. The written grievance or complaint is delivered to a designated consortium officer—the chairperson, the president or a committee chairperson.
2. The recipient acknowledges receipt of the complaint in writing within a specified number of days.
3. The recipient or his/her designee meets with the complainant with the goal of rectifying the situation in a mutually satisfactory way.
4. If resolution of the grievance is not achieved, a grievance committee (either standing or ad hoc) is convened to conduct an investigation, hold a hearing and pursue a solution. The grievance committee is sometimes composed of community leaders unaffiliated with the consortium or consortium-funded services, such as

attorneys, judges and professional mediators.

5. The membership grievance committee can render either a final decision or a recommendation to be forwarded to the full membership for a vote.

### What is the consortium's responsibility to an agency appealing a funding decision?

The consortium should provide agencies seeking funding with a procedure for registering grievances and appeals. Such appeals should be explicitly confined to irregularities in the decision process and inconsistencies or errors in findings of fact. The procedure should specify the officer or committee to whom the grievance should be addressed, the amount of time after notification of the funding decision within which the appeal must be filed, and who will make the final decision (the appeals committee, the executive committee or the full membership). The appeal should be accompanied by supporting documentation of the alleged irregularity, error or act of omission on the part of the consortium.

The designated officers or committee should review the appeal to determine whether a basis for the appeal exists, and notify the complainant of the decision. If a basis for appeal exists, a fact-finding investigation should be conducted, followed by a hearing and a decision.

# REFERENCES

R

# References


### Bylaws

American Bar Association Committee on Corporate Laws. *Model Nonprofit Corporation Act.* Philadelphia: ABA, 1964.

Child Welfare League of America. *Guide for Board Organization in Social Agencies,* rev. ed. New York: CWLA, 1975.

Connors, Tracy D. "Controlling Instruments of the Nonprofit Organization: By-Laws and the Articles of Incorporation," in: *The Nonprofit Organization Handbook.* New York: McGraw-Hill, 1980.

Oleck, Howard L. *Nonprofit Corporations, Organizations, and Associations* 5th ed. Englewood Cliffs, NJ: Prentice-Hall, 1988.

### Conflict Management and Negotiation

Carpenter, Susan. *Solving Community Problems by Consensus.* Washington, DC: Program for Community Problem Solving, 1990.

Creighton, James L. *Involving Citizens in Community Decision Making: A Guidebook.* Washington, DC: Program for Community Problem Solving, 1992.

Fisher, Roger and Brown, Scott. *Getting Together: Building Relationships as We Negotiate.* New York: Penguin Books, 1989.

Fisher, Roger, and Ury, William L. *Getting to Yes: Negotiating Agreement Without Giving In.* New York: Penguin Books, 1991.

Gudykunst, William B. *Bridging Differences: Effective Intergroup Communication.* Newbury Park, CA: Sage Publications, 1991.

Institute for Conflict Analysis and Resolution. *An Introduction to Negotiation and Conflict Resolution.* Fairfax, VA: George Mason University, 1994.

Moore, Christopher W. *Mediation Process: Practical Strategies for Resolving Conflict.* San Francisco: Jossey-Bass, 1986.

Ury, William L. *Getting Past No: Negotiating Your Way from Confrontation to Cooperation.* New York: Bantam, 1994.

Ury, William L., Brett, J., and Goldberg, S. *Getting Disputes Resolved: Designing Systems to Cut the Cuts of Conflict.* San Francisco: Jossey-Bass, 1988.

### Conflict of Interest and Codes of Conduct

"Improper Business Practices and Personal Conflicts of Interest." *Code of Federal Regulations* Title 48, Part 3.

*Managing the Conflict of Interest Challenge* (TA Topic #1). Rockville, MD: US DHHS HRSA BHRD Division of HIV Services, September 1992.

*PHS Grants Policy Statement.* Rockville, MD: US DHHS Public Health Services Office of the Assistant Secretary for Health, April 1994.

*Ryan White Title II Constituency Discussion Group Meeting: Summary Report.* Rockville, MD: US DHHS HRSA BHRD Division of HIV Services, August 9-10, 1993.

"Standards of Conduct." *Code of Federal Regulations* Title 45, Part 73.

**Consortium Development and Management**

*Activities of Ryan White CARE Act Title II HIV Care Consortia,* FY 1993 Rockville, MD: US DHHS HRSA Division of HIV Services, October 1994.

*Assessing Needs and Coordinating Care: A NASTAD Review of State Decision-Making Processes Under Title II of the Ryan White CARE Act (Draft).* Rockville, MD: US DHHS HRSA Division of HIV Services, October 1994.

*Development Models for PWA Coalitions: A Training Booklet.* Washington, DC: National Association of People with AIDS, 1994.

*Information about the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, The CARE Act, Public Law 101-581.* Rockville, MD: US DHHS HRSA Bureau of Health Resources Development, August, 1990.

John Snow, Inc. *Formation and Operation of Coalitions to Provide Health Care Services to People with HIV Illness.* Rockville, MD: US DHHS HRSA Bureau of Health Resources Development, 1993.

McKay, Emily Gantz, and Borrego, Vicky J. *Grievance Procedures within Ryan White CARE Act Programs.* Rockville, MD: US DHHS HRSA BHRD Division of HIV Services, December 1994.

McKinney, Martha, and Bragg Kirk. "Building an HIV Care Network in Central Iowa." *AIDS and Public Policy* 9 (3): 111-119.

McKinney, Martha. "Consortium Approaches to the Delivery of HIV Services under the Ryan White CARE Act." *AIDS and Public Policy 8* (3): 115-125.

Mor, Vincent; Fleishman, John A.; Allen, Susan M.; and Piette, John D. "Consortium Structure and Operations." in *Networking AIDS Services.* Ann Arbor, MI: Health Administration Press, 1994.

Mor, Vincent; Fleishman, John A.; Piette, John D.; and Allen, Susan M. "Developing AIDS Community Service Consortia." *Health Affairs* 12 (1): 186-199.

Myers, Adam M.; Pfeiffle, Peter; and Hinsdale, Kirsten. "Building a Community-Based Consortium for AIDS Patient Services." *Public Health Reports* 109 (4): 555-562.

*Participation of People with HIV in Title I HIV Health Services Planning Councils: Final Report,* Academy for Educational Development AIDS Communication Support Project. Rockville, MD: US DHHS Health Resources and Services Administration, September 1994.

*Policy Issues Relative to HIV CARE Consortia: Draft Discussion Paper.* Rockville, MD: US DHHS HRSA BHRD Division of HIV Services, 1993.

*Resources Manual: Title I Newly Eligible Metropolitan Areas.* Rockville, MD: US DHHS HRSA BHCD Division of HIV Services, December 1994.

*Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Public Law 101-381.* Washington, DC: Government Printing Office, August 18, 1990.

*Standard Protocol for Initial Needs Assessment Data Collection: Basis for a Community HIV Needs Assessment Process,* Rockville, MD: US DHHS HRSA BHRD Division of HIV Services, June, 1994.

Weisfeld, Victoria D. *AIDS Health Services at the Crossroads: Lessons from Community Care.* Princeton, NJ: Robert Wood Johnson Foundation, 1991.

### Meeting Management

*A-B-Cs of Parliamentary Procedures.* South Deerfield, MA: Channing L. Bete Company, 1974.

O'Connell, Brian. "Robert's Rules of Order—Demystified." in: *Board Member's Book: Making a Difference in Voluntary Organizations.* New York: Foundation Center, 1985.

### Nonprofit Management

Albert, Sheila. "Eight Steps to Productive Committees" *Nonprofit World 6* (4): 24-25.

Axelrod, Nancy R. *Creating and Renewing Advisory Boards: Strategies for Success,* NCNB Governance Series Booklet 9. Washington, DC: National Center for Nonprofit Boards, 1990.

"Board Members and Risk: A Primer on Protection from Liability." *Board Member* 1 (6): 1-16.

Hirzy, Ellen Cochran. *Nonprofit Board Committees: How to Make Them Work.* Washington, DC: National Center for Nonprofit Boards, 1993.

Leifer, Jacqueline C., and Glomb, Michael B. *Legal Obligations of Nonprofit Boards: A Guidebook for Board Members.* Washington, DC: National Center for Nonprofit Boards, 1992.

Nelson, Judith Grummon. *Six Keys to Recruiting, Orienting, and Involving Nonprofit Board Members.* Washington, DC: National Center for Nonprofit Boards, 1991.

*Policy and Procedures Manual for Governing Board Members.* DHEW Pub. (HSA) 78-5502. Rockville, MD: US DHEW Bureau of Community Health Services, 1978.

Robinson, Maureen K. *Developing the Nonprofit Board: Strategies for Orienting, Educating, and Motivating Board Members.* Washington, DC: National Center for Nonprofit Boards, 1994.

Saphier, J.; Bigda-Peyton, T.; and Pierson, G. *How to Make Decisions That Stay Made.* Alexandria, VA: Association for Supervision and Curriculum Development, 1989.

# APPENDICES

# A

# Appendix A: Methods of Fund Distribution and Sample RFA

### Invitation for Bid (IFB)

An IFB says, in effect, "Here is exactly what we want. How much will you charge us to provide it?" Because an IFB itemizes specific requirements, choosing among bids is a matter of determining which providers meet the requirements, and then which among them submitted the lowest bid (and is not disqualified due to mistake or fraud).

### Letter of Intent

With this method, the consortium specifies the services required and the monies available for each and requests letters of intent from prospective providers. This initial screening stage helps the consortium determine which and how many agencies are interested. Some consortia in small counties with few providers have adopted the letter of intent—including a brief proposal and budget—as the final application.

### Request for Application (RFA)

This is a competitive process. The consortium specifies the services required, and the prospective service providers apply and then negotiate a budget with the consortium. This process allows the consortium to focus on the quality and magnitude of services provided, by contrast to the traditional RFP approach of determining in advance exactly how much a service will cost. It also allows for flexibility and creativity on the part of prospective service providers.

### Request for Proposal (RFP)

In the traditional RFP process, the consortium specifies the services required and the monies available for each. Prospective service providers submit proposals describing how they would perform the service required and for how much money. A modified or mini-RFP is more streamlined, requiring less supportive documentation from the applicant.

### Sole-Source Funding

When there is only one provider of a given service in a community, there can be no competitive process; the consortium simply negotiates with the provider. However, the consortium must still define criteria for granting funds and must also demonstrate conclusively that there is indeed only one source in the community. To ensure that the costs are justified, the consortium should require cost information sufficient to support and justify the contract, cost information for similar services (differences should be noted and explained) and special factors affecting costs under this contract.

**VENTURA COUNTY HIV CARE CONSORTIUM**
P.O. Box 1641 • Ventura CA • 93002

FY-96 REQUEST FOR APPLICATION

**YEAR FIVE**
**CARE ACT TITLE II - $195,367 IS AVAILABLE FOR SERVICES SUCH AS:**

- Case Management
- Psycho-Social Counseling
- Outpatient and Support Services
- Emergency Subsidies (food, medications, etc....)
- Transportation
- Dental

**YEAR FOUR**
**HOUSING OPPORTUNITY FOR PEOPLE WITH AIDS (HOPWA) - $109,481 IS AVAILABLE FOR SERVICES SUCH AS:**

- Rental Assistance
- Housing Unit Development
- Technical Assistance
- Operating Costs
- Utilities
- Housing Outreach

The Ventura County HIV Care Consortium is an association of public and private, non-profit and for-profit organizations and interested individuals. The Consortium was formed by local community-based organizations in response to Title II of the Federal Comprehensive AIDS Resources Emergency (CARE) Act. The goal of the Consortium is to ensure a continuum of care for the HIV-affected community in Ventura County. This effort represents a significant step in community coordination of planning, funding and allocations relative to HIV/AIDS services in Ventura County.

Applications will be considered for programs which will enhance the quality of life and care for people infected with HIV or diagnosed with AIDS, with a special emphasis on low-income, uninsured and/or under-insured people. Funding priorities will be established with consideration to a most recently completed needs assessment.

**WHO IS ELIGIBLE TO APPLY:**

Applicants must be organizations, public entities or Health Care practitioners serving the population of Ventura County with a program addressing the HIV/AIDS epidemic. Applicants must be organized and operated so that they do not discriminate in hiring staff, or providing services on the basis of race, religion, sex, age, sexual orientation, national origin or disabilities. Applicants must include

services to low-income, uninsured and/or under-insured persons with HIV. Services may only be provided to individuals residing in Ventura County.

**DEADLINE:** Applications must be received by **5 p.m., Thursday, April 13, 1995.**

**THERE WILL BE NO EXCEPTIONS TO THIS DEADLINE**
**FAXED PROPOSALS WILL NOT BE ACCEPTED**

**MAIL TO:** Attn: Susan Attaway, Ventura County HIV Care Consortium, P.O. Box 1641, Ventura, CA 93002

**OR DELIVER TO:** Susan Attaway, 3210 Foothill Road, Ventura, CA 93003

APPLICATION WORKSHOP: Thursday, March 9, 1995, 3:00 p.m.-4:30 p.m.
St. John's Regional Medical Center
1600 North Rose Avenue, Oxnard
Garden Level, Conference Rooms 5 & 6

CONTACT PERSON/TECHNICAL ASSISTANCE: For questions or assistance with applications, please contact:

**DOUG GREEN** 805/643-0446 **SUSAN ATTAWAY** 805/652-5905

DEFINITIONS:

**Advocate:** An individual not representing any agency, as defined by the Consortium, who represents the perspectives of HIV infected persons in Ventura County.

**Agency:** A service organization with a specific and distinct mission that includes direct and indirect services to HIV infected persons in Ventura County.

**Benefits Counseling Assistance & Management:** Assists client in obtaining and verifying benefits such as State Disability Insurance, Medi-Cal, Social Security, SSI, and private insurance.

| | |
|---|---|
| **Case Management:** | Case management is the process through which the case manager provides initial and ongoing client needs assessment; development, implementation, and evaluation of health and support service plans; locates, coordinates and monitors cost-effective, timely delivery of quality services; and advocates for the client. |
| **Family:** | A unit of interdependent and interacting persons related together over time by strong social and emotional bonds and/or by ties of marriage, birth and adoption. |
| **PLWA:** | Person Living With AIDS |

CARE ACT TITLE II FUNDS

The purpose of the CARE grant is to improve the quality, availability and organization of comprehensive outpatient health care and support services for all individuals and families dealing with HIV disease. Services should be targeted to populations that have been underserved with special emphasis on populations with emerging HIV incidence. As identified in the legislation, special populations affected include:

- Disabled
- Homeless
- Hemophiliacs
- Children
- Gay Men of Color
- Immigrants/Undocumented Persons
- Gays and Lesbians
- Incarcerated
- Women
- Adolescents
- Alcohol & Other Drug Abusers
- Ethnic Groups

APPROPRIATE USES OF CARE ACT TITLE II FUNDS:

Services to be provided are comprehensive health care and support services **(APPENDIX "A" FOR GLOSSARY OF SERVICE CATEGORIES),** which may include, but are not limited to;

**Health Care Services:** Case management; dental care; prescription drug reimbursement; health insurance; home health care (including para-professional care, professional care and specialized care); durable medical equipment; HIV related medications and/or supplies; hospice care (including home-based and residential); mental health therapy; medical care; nursing home care; rehabilitation care; and substance abuse treatment.

**Support Services:** Adoption/Foster care assistance; attendant care services; benefits counseling; buddy/companion services (including coordination of volunteer services); client advocacy; counseling; day and respite care; direct emergency financial assistance; education/risk reduction; food bank/home delivered meals; homemaker/health aide; housing assistance; housing services (residential); information and referral/information dissemination; legal services; nutritional services; transportation; and other support services.

### CARE ACT FUNDS TITLE II RESTRICTIONS:

- CARE ACT funds cannot comprise more than 60% of the overall organizational budget. Funds cannot be used for anything reimbursable by other state or federal contracts. No funds can be used to purchase or improve (other than minor remodeling) any building or facility. Equipment purchases are limited to minor expenditures required to sustain direct services. Capital equipment purchases will not be funded. No funds can be used to make cash payments to intended recipients of services. The funds are not intended for the establishment of new organizations. Applicants must provide itemized documentation of each group served within the identified service categories of Case Management, Psychological/Social Counseling, Emergency Subsidies (Food, Medications, etc...), Transportation and Outpatient and Support Services. Applicants must be aware that 20% of the whole budget is committed to the care of women, infants, children and families.
- Written materials including, but not limited to newsletters, brochures, pictorials and like documents paid for with CARE Act Title II Funds must acknowledge the funding source. The following is suggested language: "Funding for this document/project is provided by Title II of the Ryan White CARE Act, administered by the California Department of Health Services, Office of AIDS." A copy of said document must be forwarded to your Consortia Liaison.
- No funds can be used to pay for automobile parts, repairs or maintenance.

### HOPWA FUNDS

Those eligible to receive HOPWA funds are low-income persons with AIDS or related diseases and their families. Low-income is defined as any individual or family whose income does not exceed 80 percent of the median income for the county, as determined by HUD, with adjustments for smaller and larger families.

**APPROPRIATE USE OF HOPWA FUNDS:**

A maximum of 25 percent may be used for supportive services associated with housing. In accordance with the primary legislative intent of HOPWA, which is to provide direct housing assistance for PLWAs, the balance of funds must be used for direct housing assistance activities such as short-term rent, mortgage and utility payments.

The following activities may be carried out with HOPWA funds:

1. Short-term rent, mortgage and utility payments to prevent the homelessness of the tenant or mortgagor of a dwelling;

2. Housing information services including, but not limited to, counseling, information and referral services to assist an eligible person to locate, acquire, finance and maintain housing. This may also include fair housing counseling for eligible persons who may encounter discrimination on the basis of race, color, religion, sex, age, national origin, familial status or handicap.

3. Resource identification to establish, coordinate and develop housing assistance resources for eligible persons (including conducting preliminary research and making expenditures necessary to determine the feasibility of specific housing related initiatives);

4. Operating costs for housing, including maintenance, security, operation, insurance, utilities, furnishings, equipment, supplies, staff training and recruitment, and other incidental costs;

5. Technical assistance in establishing and operating a community residence, including planning and other pre-development or pre-construction expenses and including, but not limited to, costs relating to community outreach and educational activities regarding AIDS or related diseases for persons residing in proximity to the community residence;

6. Supportive services associated with housing include, but are not limited to: case management; health and mental health assessment; permanent housing placement; drug and alcohol abuse treatment and counseling; day care; nutritional services; intensive care when required (related to keeping the person in their residence, but not related to "intensive care" for health emergencies); and assistance in gaining access to local, state, and federal government benefits and services. **Health services may only be provided to individuals with HIV/AIDS and not to family members of these**

**individuals.** For any individual with HIV/AIDS who requires more intensive care than can be provided in housing assisted with HOPWA resources, the grantee shall assist with locating a care provider who can appropriately care for the individual and refer the individual to the care provider.

7. Acquisition, rehabilitation, conversion, or release and repair of facilities to provide housing and services.*
8. New construction (for single room occupancy [SRO] dwellings and community residences only)*:
9. Project and/or tenant based rental assistance.

**REQUIRED SUPPORTIVE SERVICES:** APPROPRIATE SUPPORTIVE SERVICES MUST BE PROVIDED AS PART OF ANY HOPWA ASSISTED HOUSING AND MAY BE PROVIDED INDEPENDENTLY OF ANY HOUSING ASSISTANCE.

***These activities require environmental review prior to the expenditure of funds.**

## RESTRICTIONS ON HOPWA FUNDS

Payments exceeding the following time limits for short-term supported housing:

1. Rental assistance for a short-term housing facility (such as a room in a hotel) may not be provided for more than 60 days during any six-month period; and
2. Short-term rent, mortgage and utilities payments to enable eligible individuals to remain in their own dwellings may not be provided for more than 21 weeks in any 52 week period.

| | | |
|---|---|---|
| **TIME LINE:** | Application Process Begins: | **March 1, 1995** |
| | Application Workshop: | **March 9, 1995** |
| | Close Applications: | **April 13, 1995** |
| | Announce Funding Decisions: | **May 3, 1995** |
| | Appeals Due By: | **May 10, 1995** |

## APPLICATION REVIEW PROCESS:

The members of the Allocations Committee, lacking any conflict of interest, will review all applications. The Committee's recommendations will be presented to the general Consortium membership for the final vote of approval.

## EVALUATION CRITERIA

Applications will be evaluated using a standard format developed by the Allocations Review Committee & approved by the Consortium (APPENDIX "B").

## INVOICING AND REPORTING REQUIREMENTS

All grant recipients will provide monthly reports and invoices on their program's activity to the Consortium. Reports are to include units of service, demographics, expenses, and ongoing assessment of unmet needs. Reports will be due within 15 days after the last day of the month.

A plan for monitoring the quality assurance of the service rendered must be submitted to the Executive Committee within 90 days from the first effective day of the contract for all grantees.

## GRIEVANCES AND APPEALS:

It is the intent of the Ventura County HIV Care Consortium to provide an appropriate process by which individuals and/or agencies may set forth grievances and appeal decisions of the Consortium. The procedures adopted by the Consortium are intended to enhance timely factfinding, hearing and decision making in the event of a grievance or appeal. (APPENDIX "C")

## VENTURA COUNTY HIV CARE CONSORTIUM NEEDS ASSESSMENT

After surveying individuals and agencies within Ventura County, the Services Committee of the Consortium has summarized the identified needs as follows:

| | | |
|---|---|---|
| Dental care | Transportation | Housing/Utilities assistance |
| Pharmaceutical assistance | Health insurance | Legal assistance |
| Financial assistance | Food assistance | Nutritional counseling |
| Support groups | Home health care | Social services counseling |
| Psychosocial counseling | HIV/AIDS counseling | Medical care |

In addition, case management and benefits counseling are mandated by the legislation to be provided with a portion of Title II/CARE Act funds.

*Remaining pages of RFA not included here.*

# Appendix B: Sample Memorandum of Understanding

## Sample Memorandum of Understanding (MOU) between an HIV Care Consortium and a Lead Agency

*Note: The sample MOU is intended to serve as the basis for thoughtful discussion at the local level. Language is representative, not prescriptive. Each consortium, in consultation with a local attorney, should determine the precise language that best addresses local needs and conditions.*

**Background:**

The HIV Care Consortium is an association of one or more public, and one or more nonprofit private, health care and support service providers and community-based organizations operating within areas determined by the State to be most affected by HIV disease. A consortium must include agencies and community-based organizations with records of service to populations and subpopulations with HIV disease requiring care within the community to be served.

The lead agency is authorized to receive funds from the State and distribute them according to the service priorities established by the consortium. The lead agency shall fund the activities and services in accordance with the consortium's HIV Care Plan.

**Agreement:**

The *enter name of consortium*, hereafter known as the Consortium, agrees that the *enter name of lead agency*, hereafter known as lead agency, shall sign a contract with the State to serve as lead agency for the receipt and disbursement of funds available for *name of service area* through Title II of the CARE Act according to the provisions listed herein with which both parties agree to comply.

This memorandum covers the period commencing *enter start date of MOU* and will continue from year to year until such time that it is cancelled by either party. The Consortium agrees that the *name of lead agency* shall receive 10% of the Title II funds awarded to the Consortium to carry out its responsibilities as lead agency. This memorandum may be cancelled with thirty (30) days written notice by either party.

**The Consortium agrees to:**

1. Establish and maintain HIV service priorities for the allocation of funds through Title II of the CARE Act.
2. Develop and maintain a comprehensive plan for the organization and delivery of HIV health and support services to individuals with HIV.

3. Assess the ongoing efficiency of the administrative mechanism in allocating funds rapidly to areas of greatest need.
4. Assist in conducting or updating an assessment of HIV/AIDS service needs for the geographic service area.
5. Coordinate and integrate the delivery of services.
6. Evaluate the cost-effectiveness of the Consortium's response to identified needs.
7. Work with case management services to ensure a coordinated system of care.
8. Conduct monthly meetings of the consortium.

**The Lead Agency agrees to:**

1. Sign a contract with the State to act as lead agency for the Consortium and include this document as an exhibit to that contract.
2. Appropriate and disburse funds in compliance with priorities established by the Consortium and in accordance with generally accepted accounting procedures and to maintain records of all transactions in good order and available for inspection.
3. Develop and execute Memoranda of Understanding or subcontracts with providers for services prioritized by the Consortium.
4. Review and process (either approve or promptly return to submitting agency for correction or clarification) all invoices and other requests for reimbursement from subcontractors, and ensure that all approved requests conform to line item expenses in the Agreement between the lead agency and subcontractor.
5. Prepare and submit invoices/cost reports required by the State in a timely manner.
6. Maintain fiscal records for five years.
7. Ensure that all subcontractors have adequate organizational and fiscal accountability systems in place prior to program commencement.
8. Generate and prepare any and all proposals and programmatic, fiscal or data reports required by the State.
9. Monitor and evaluate contract performance by subcontractors and prepare State-required reports.
10. Provide periodic reports to the Consortium on the implementation status of the HIV Care Plan, including information on the status of the Consortium's overall budget.

11. Convene monthly meetings of the Consortium including providing meeting space, notifying members of meeting time and location and preparing and distributing meeting minutes.

**Both parties agree jointly:**

That the lead agency shall be held harmless from liability for acts taken at the direction of the Consortium; and moreover, shall be held harmless from liability for an acts by the Consortium or its delegates or associated agencies, including but not limited to the misuse or misallocation of funds, error, malfeasance, or failure to report in a timely manner, or any other acts that may cause the State or federal government to seek recovery of contracted funds.

This memorandum may be amended by written agreement of both parties.

(signature for lead agency) (date)

(signature for Consortium) (date)

# APPENDIX C: SAMPLE BYLAWS

***Note:*** *The sample bylaws are intended to serve as the basis for thoughtful discussion at the local level. Language is representative, not prescriptive. Each consortium, in consultation with a local attorney, should determine the precise language that best addresses local needs and conditions.*

## ARTICLE I: NAME AND OFFICES

*List the official name of the Consortium; the state, county and city that serves as the home body or lead agency of the Consortium; other office locations of importance, such as fiscal agencies, registered agents, etc.; and the duration of the Consortium.*

### Section 1.1. Name

This organization shall be known as the [*name*] serving the [*service area*] and located in the state of [*name state*]. The main offices of the Consortium shall be located at [*name and address of lead agency or coordinating site*] until such time as the executive committee may determine it necessary or appropriate to relocate.

### Section 1.2. Duration

The existence of the Consortium shall be perpetual, except that it may be terminated by a majority decision of its members.

## ARTICLE II: STATEMENT OF PURPOSE

*Clearly state the purpose of the Consortium as well as the specific services that the Consortium and its member agencies are currently providing for people living with AIDS.*

The Consortium shall be responsible for the administration of services authorized under Title II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and other applicable local, state and federal funds appropriated for the affected populations. The purpose of the Consortium is: (a) to serve as a planning body for health and social services for people with HIV disease/AIDS; (b) to promote greater cooperation among all agencies delivering HIV-related health and human services; (c) to solve problems collaboratively regarding the major issues in health, social service and quality of life for people with HIV disease living in the service area; (d) to assure a comprehensive continuum of care is available to all people in the service area who are infected or at risk for infection with HIV; (e) to provide information to community providers and residents in order to increase accessibility and visibility of HIV-related services; and (f) to monitor implementation plans of service providers and evaluate services provided.

ARTICLE III : POLICIES

Section 3.1. Conflict of Interest

This Consortium functions exclusively for charitable and educational purposes. No part of its net earnings shall inure to the benefit of, or be distributable to its members, trustees, officers or other private persons, except that it shall be authorized to pay reasonable compensation for contracted services and to make payments and distributions on furtherance of the purpose set forth above. No representative or employee of any member agency may vote on any administrative or fiscal matter pertaining to Consortium-distributed grants to said agency or be present when a vote is taken relevant to grant funds for the agency.

Conflict of interest occurs when a voting member of the Consortium has a direct or indirect fiduciary interest in or relationship to (including but not limited to ownership, employment, contractual, creditor or consultative relationship; or to Board or staff membership in) a business, organization, program or other entity and (1) the Consortium has a direct financial, contractual or other recognized relationship with the such entity, and/or (2) such entity is the direct or indirect subject of a decision by the Consortium.

Section 3.2. Disclosure of Conflict of Interest

All persons or groups subject to Section 3.2 shall identify and disclose to the Consortium, or to the Consortium's appropriate agent or designee, all conflicts of interest as defined above. All directors and committee members upon election, appointment or hire, shall complete and sign a Conflict of Interest Disclosure form. Complete disclosure forms shall be kept on file by the Consortium or its appropriate agent or designee. Directors and committee members shall review and update their disclosure forms annually, or as otherwise precipitated by material change in employment, fiduciary, financial or other relevant interest or status.

Section 3.3. Regulation of Conflict of Interest

Members shall be provided with applicable local, state and federal rules governing conflict of interest. A standing Conflicts Oversight Committee shall oversee matters relating to conflicts of interest. Directors and committee members shall be mandatorily excused and shall not vote on any matter in which they have an actual, disclosed or determined conflict of interest. Abstaining persons may be counted toward the quorum for meetings and may participate in discussions. Directors and committee members who refuse or fail to comply with the conflict of interest provisions shall be subject to termination from their positions by the Board.

Section 3.4. Lobbying

This Consortium shall not participate or intervene in any political campaign on behalf of any candidate for public office (including the publishing or distribution of statements).

Section 3.5. Dissolution of the Consortium

In the event of dissolution or termination, no member, trustee, officer or employee of the Consortium shall receive any assets of the Consortium other than as reasonable compensation for services rendered or in repayment of sums loaned or advanced to the Consortium. Funds or property remaining in the holdings of the Consortium upon its dissolution shall be donated to a charitable organization of the membership's choosing.

Section 3.6. Order of Business

Robert's Rules of Order shall be used to ensure order at all meetings.

Section 3.7. Change of Bylaws

These bylaws may be amended, revised or otherwise changed at any annual meeting or a meeting of the membership, provided that written notice of the proposed action is given in the call to the meeting. Amendments and revisions will be accepted upon approval of a two-thirds (2/3) vote of the members present.

Section 3.8. Personal Liability

*It is essential to consult with a local attorney to ensure that language used provides maximum protection under state law.*

The members and officers of the Consortium shall not be personally liable for any debt, liability or obligation of the Consortium. All persons, corporations or other entities extending credit to, contracting with or having any claim against the Consortium may look only to the funds and property of the Consortium for payment of any such contract or claim, or for payment of any debt, damages, judgment or decree, or of any money that may otherwise become due or payable to them from the Consortium.

Section 3.9. Compensation

The chairpersons and members of committees shall not be compensated for their services. A stipend to cover travel and meal expenses may be allowed for members representing persons living below the poverty level.

## ARTICLE IV: MEMBERSHIP

*State categories or classes of membership, and specify the process for the election or selection, termination, resignation, reinstatement and transfer of membership status. In some cases it is possible that the Consortium will have no members but will operate under the administration of a lead agency*

*with fiduciary authority. In this case, this article should contain a no-membership clause. In some consortia, members are defined as partners. If dues are collected for some categories of membership — such as contributors — a dues section should be specified.*

Section 4.1. Number

The number of members shall not be less than [*list number*] nor more than [*list number*]. No more than [*list number*] representatives from a single organization may be a member of the Consortium.

Section 4.2. Eligibility

The Consortium shall be open to any agency, organization or individual residing or working in the Consortium's service area that demonstrates affirmative interest and concern to improve the health and social welfare of people living with AIDS.

Section 4.3. Recruitment of Members

It shall be the policy of this Consortium to appoint and retain persons from all represented service areas, infected and affected population groups and various fields of expertise, including people who have an active interest in the care of persons living with AIDS and HIV.

Section 4.4. Election or Selection of Members

*The process for electing or selecting members will vary based on the geographic coverage of the consortium, its organizational structure, the intended size of its membership and types of members. Chapter 6 discusses issues to consider in defining membership. The following is a representative section for a multi-county consortium.*

Each county within the service area of the Consortium shall have at least [*list number*] representatives unless no person can be recruited. Representatives from the following agencies or organizations shall be recruited for membership: (a) AIDS services organizations; (b) business groups; (c) community-based organizations; (d) educational institutions; (e) elected government officials; (f) financial institutions; (g) home health agencies; (h) hospice organizations; (i) hospitals; (j) medical, public health and social services societies; (k) mental health agencies; (l) minority groups; (m) people living with AIDS; (n) public health and social services departments; (o) religious groups; and (p) support groups.

Appropriate action will be taken to recruit a membership that reflects the economic, social, racial, ethnic, sexual orientation and gender composition of the population served. Affirmative action shall be take to recruit [*state number*] persons infected with HIV or their family members or personal caregivers.

Section 4.5. Duties

*The duties of members will vary based on the purpose(s) of the consortium, its organizational structure, and the number and types of members. The following are examples of duties that could be specified.*

Members agree to (a) participate in the planning, implementation and evaluation of a comprehensive service plan for people living with AIDS; (b) participate actively on at least one Consortium committee; (c) participate in continuing education relative to the Consortium's interests at least once a year; and (d) assist in providing information, referral, advocacy, support and education regarding HIV and AIDS.

Section 4.6. Membership Terms

Members may apply and/or shall be invited to join the Consortium and will be admitted upon submitting a signed Consortium Membership Agreement. The Agreement will be renewed with each term of membership.

Section 4.7. Resignation

Any active member may at any time resign as an active member of the Consortium by submitting a written resignation to the president, to be effective upon receipt by the chairperson.

Section 4.8. Removal

Any active member may be removed, with or without cause, by a majority vote at an executive committee meeting at which a quorum is present, provided that no action will be taken to remove an active member unless such an action has been previously recommended by a majority vote of the nominating committee. Any member who misses three or more consecutive meetings of the Consortium shall be regarded as inactive and may be removed from membership, providing that such action has been reviewed and recommended by a majority vote of the nominating committee.

## ARTICLE V: MEETINGS OF MEMBERS

*The following should be specified: types of meetings, frequency of meetings, date of the annual meeting, manner by which meetings are called, process for calling special meetings, and number of members that constitute a quorum.*

Section 5.1. Annual Meeting

The annual meeting shall be held [*state season or month*]. The hours, date and location of the regular meeting shall be determined by the president. The secretary will provide written notice of the regular meeting at least two weeks prior to the meeting date.

Section 5.2. Special Meetings

The executive committee may call special meetings by giving the active members at least ten days' written notice in advance of the proposed meeting.

Section 5.3. Committee Meetings

The executive committee shall meet regularly on [*state time interval*] and upon call by the president for the purpose of performing urgent business that cannot be handled by a functioning standing committee. Standing and ad hoc committees shall meet at such times as necessary.

Section 5.4. Quorum

A quorum shall consist of a simple majority vote of members present providing that number is at least ten (10) and that proper notification of meeting was sent. A member who is not able to attend a Consortium meeting may send an alternate to receive information and to vote.

Section 5.5. Voting and Proxies

Each member shall have one (1) vote at a meeting, exercisable only if the member or a representative is personally present at the meeting. A member shall be permitted to give his or her proxy to another member or to another person providing that such permission is presented to the president in writing.

## ARTICLE VI: BOARD OF DIRECTORS

*This section should include a statement of the board's overall responsibility and should specify the number of members on the board of directors. The board may delegate its powers to committees but retains ultimate responsibility for the Consortium.*

The affairs of the Consortium shall be governed by its Board of Directors. The board shall foster communication, collaboration, cooperation and advocacy in a comprehensive, integrative approach to meeting with compassion and dignity the multifaceted needs of persons affected with AIDS and their families. The board shall be composed of the president, vice-president, treasurer and secretary. The board shall meet regularly with the executive committee and as needed to conduct business.

## ARTICLE VII: OFFICERS

*The following should be addressed: the officers' overall responsibilities, the number of officers allowed, the time and process for elections, the process for filling vacancies, the process for removing directors from office, term lengths, ex-officio status and a compensation clause.*

Section 7.1. Election of Officers

At the annual meeting in even-numbered calendar years, members shall elect from among their number a president and treasurer to serve for a two-year term. At the annual meeting in odd-numbered calendar years, members shall elect from among their number a vice-president and secretary to serve for a two-year term. Candidates receiving the highest number of votes of the members present shall be deemed elected. All candidates for office shall have served as a member of the Consortium for one year. In the event of a vacancy of any officer, occurring for any reason including death, incapacity or resignation, the president will appoint a successor to serve the unexpired term. The officers may serve a maximum of two consecutive two-year terms.

Section 7.2. Removal

Any appointed or elected officer may be removed at any executive committee meeting *(or another specified committee or body)*, with or without cause, by a majority vote of the executive committee members present, provided that no action will be taken to remove an officer unless such action has been recommended by the executive committee.

Section 7.3. Compensation

The officers of the Consortium will not be compensated for their services. A stipend to cover travel and meal expenses may be allowed for members representing persons living below the poverty level.

Section 7.4. President/Chairperson

The president shall: (a) preside at the annual meetings, all special meetings and all meetings of the executive committees; (b) appoint the chairpersons of all committees except the nominating committee; and (c) be an ex-officio member with voting privileges of all standing committees except the nominating committee and except when such appointment is reserved by these bylaws.

Section 7.5. Vice-President/Vice-Chairperson

The vice-president shall: (a) serve as leader of the Consortium in the president's absence or under the president's direction; (b) preside at meetings in the president's absence; (c) serve as an honorary member of all standing committees, with no voting rights except as a tie-breaker; and (d) perform other duties as assigned by the president.

Section 7.6. Treasurer

The treasurer shall: (a) be responsible for all financial business; (b) keep or oversee the keeping of an accurate account of all money received and spent; (c) report to the executive committee and to the membership at regular intervals on the Consortium's finances and on the administration of the finances of the Ryan White CARE grant; and (d) sign all checks and pay all bills.

Section 7.7. Secretary

The secretary shall: (a) keep accurate minutes of the annual, special and executive committee meetings and arrange for their distribution; (b) give notices of annual and special meetings; and (c) keep a current list of members.

## ARTICLE VIII: COMMITTEES

*Several committees are essential to a consortium to ensure continuity and management control. These include the executive, finance, nominating, personnel, program or services (often referred to as task forces), social policy and public relations committees, among others. Each committee's functions, responsibilities and procedures for reporting to the executive committee should be specified in detail in the Bylaws. Chapter 8 discusses standing and ad hoc committees often present in consortia. Some examples follow.*

Section 8.1. General Conditions

The terms of membership on committees shall be for two (2) years unless otherwise specified by the appointed authority. A majority of the members of a committee present at a meeting shall constitute a quorum for the transaction of business. Each committee chairperson shall (a) provide a written report of committee activities for the annual report; (b) report committee activities at executive committee meetings; (c) obtain executive and finance committee approval of projects and budget requests; (d) maintain committee files to pass on to new committee members.

Section 8.2. Executive Committee

The executive committee shall foster communication, collaboration, cooperation and advocacy in a comprehensive, integrative approach to meeting with compassion and dignity for the multifaceted needs of persons affected with AIDS and their families. The executive committee shall consist of the officers and chairpersons of standing committees. The executive committee shall meet regularly on [*state time interval*] and upon call by the president for the purpose of performing urgent business that cannot wait or that cannot be handled by a functioning standing committee of the Consortium. Any action of the executive committee shall be reported for ratification at the next annual meeting. A simple majority of the officers shall constitute a quorum for the transaction of business. The executive committee shall have the authority to establish and approve policies and procedures for all committees.

Section 8.3. Finance Committee

The finance committee shall be composed of the treasurer as chair of the committee and at least three other members to be appointed by the executive committee in

consultation with the treasurer. The finance committee shall report to the executive committee monthly/quarterly, and a complete auditor's report of Consortium finances shall be sent annually to each member of the executive committee. The committee shall (a) consider the details of the budget; (b) secure an accounting firm to compile or audit the accounts of the Consortium; (c) study and suggest the financial policies of the Consortium; (d) prepare a budget for approval by the executive committee; (e) serve as a resource to other committees on budget planning; and (f) research and develop additional and alternative funding sources for the Consortium. The finance committee shall have the power to buy, subscribe for, sell, exchange and transfer stocks, bonds and other securities and otherwise to reinvest and invest any funds of the agency.

Section 8.4. Nominating Committee

Members of the nominating committee shall be appointed by the executive committee to serve for a specified period of time, led by the immediate past-president. The committee shall (a) nominate officers and candidates for membership on the executive committee; (b) recommend the criteria for selection of new members; (c) provide orientation to new members; (d) analyze regularly the attendance of members; (e) consult with those who are not attending regularly or fail to attend the minimum number of committee meetings; and (f) recommend to the officers action regarding inactive members.

At least four weeks prior to presenting nominations to the members, the committee shall notify each member in writing of the names of persons it proposes to nominate, with a brief profile describing the qualifications of proposed nominees.

Section 8.5. Personnel Committee

The personnel committee, led by a chairperson appointed by the president, shall establish policies and procedures regarding salaries, fringe benefits, hours and working conditions that permit the employment and retention of qualified staff and that foster high productivity and quality of service.

The board personnel committee shall (a) be informed about the Consortium's current personnel requirements and needs, the physical conditions of offices and equipment and the Consortium's salary ranges and fringe benefits; (b) be familiar with personnel laws; (c) formulate policy on matters pertaining to personnel practices and procedures; and (d) establish procedures to hear grievances and to arrange negotiations.

The staff personnel committee shall (a) compile a personnel policy and practice manual; (b) provide for staff review and approval of its recommendations to the board personnel committee; and (c) discuss with administration any proposals for change in working conditions or personnel practices.

Section 8.6. Program or Services Committee or Task Forces

The program or services committee shall be composed of a member from each of the counties served by the Consortium and led by a chairperson appointed by the president. The committee shall (a) develop and implement policies and procedures about how services will be implemented; (b) provide the executive committee with detailed information about the Consortium and member agencies' programs and/or services; and (c) pursue continuing examination of the Consortium's services with regard to effectiveness and trends in services and needs.

Section 8.7. Public Policy Committee

The public policy committee, led by a chairperson appointed by the president, shall (a) be informed of local, state and national issues affecting people living with AIDS; (b) present issues of social policy to the executive committee so that it can formulate a position; and (c) disseminate this position through public speaking, letter-writing, and public education.

Section 8.8. Public Relations Committee

The public relations committee, led by a chairperson appointed by the president, shall inform others about the Consortium's programs and services through personal and published presentations of information to the public.

Section 8.9. Conflicts Oversight Committee

The conflicts oversight committee, led by a chairperson appointed by the president, shall be responsible for overseeing matters concerning conflicts of interest. The committee shall (a) receive requests from members or from the board to review questions of conflict of interest; (b) monitor actual or potential conflicts if interest concerning directors and committee members; (c) monitor in conjunction with the personnel committee actual or potential conflicts of interest concerning Consortium staff and consultants; (d) recommend policies and actions to the board concerning conflicts of interest; (e) recommend to the board appropriate disclosure forms which shall be consistent with applicable local, state and federal disclosure reporting requirements; and (f) perform other duties as assigned by the president.

Section 8.9. Ad Hoc Committees

Ad hoc committees may be designated by the executive committee from time to time as needed to fulfill time-limited objectives. Chairpersons are appointed by the president and report to the executive committee for the duration of their appointments.

## ARTICLE IX: CONTRACTS, CHECKS, DEPOSITS AND FUNDS

*Section 9.1. Contracts*

The executive committee may authorize any officer or officers, or agent or agents, to enter into any contract or execute and deliver any instrument in the name of, and on behalf of, the Consortium. Such authority may be general or confined to specific instances.

Section 9.2. Checks, deposits and funds

Expenditures of Consortium funds shall be made by the fiscal agency with approval from the finance and executive committees of the Consortium. A fiscal-agency representative, the president of the Consortium and the treasurer of the Consortium shall have authority to sign checks on behalf of the Consortium. Any one of these three persons will suffice, except that checks over [*specify amount*] will require two signatures. The transfer of funds requires two signatures. All funds not otherwise obligated shall be deposited to the credit of the Consortium in such depositories as the president and treasurer may select.

## ARTICLE X: FISCAL YEAR

The fiscal year of the Consortium will begin on [*state month and day*] and end on [*state month and day*].

## ARTICLE XI: BOOKS AND RECORDS

The Consortium shall make available to the appropriate state and federal agencies correct and complete written books and records of accounts and shall keep minutes of the proceedings of all meetings.

# APPENDIX D: SAMPLE DISCLOSURE FORM

**CARE Consortium Conflict of Interest Disclosure Form**

The Ryan White HIV CARE Consortium has members who are professionally or personally affiliated with organizations that have received, or may request or receive funds authorized under Title I and/or Title II of the Ryan White CARE Act. Because of the potential for conflict of interest, this Disclosure Form has been adopted by the Consortium and must be completed by all current members and candidates for membership of the Consortium.

By my signature below, I certify that:

(1) I have received, read and understood and will abide by Sections 3.1 through Section 3.4 of the Consortium's Bylaws;
and

(2) I am serving (or have served within the past twelve months) in a staff, consultant, officer, board member or advisor capacity with the following organization(s) that receives, has received or plans to seek funding under Title I or Title II of the Ryan White CARE Act of 1990:

_____

Name of Consortium Member

_____

Organization

_____

Title of Position

_____

Period of Affiliation

3) A member of my family is serving (or has served within the past twelve months) in a staff, consultant, officer, board member or advisor capacity with the following organization(s) that receives, or plans to seek funding under Title I or Title II of the Ryan White CARE Act.

Name of Family Member

Relationship

Organization

Title of Position

Period of Affiliation

Name Family Member

Relationship

Organization

Title of Position

Period of Affiliation

(Attach additional pages if necessary.)

Consortium Member (Print your name)

Signature

Date

# Appendix E: Associations and Publishers

### Conflict Management And Negotiation

- American Arbitration Association
  140 West 51st Street
  New York, NY 10020
  Telephone: 212-484-4000
  Telefax: 212-765-4874

This association is comprised of businesses, unions, trade and educational associations, law firms, arbitrators and other interested individuals. It works toward the resolution of disputes through the use of arbitration, mediation, democratic elections and other voluntary methods, and provides administrative services for these methods. A Panel of Arbitrators and Mediators is available for referrals to groups involved in disputes. Conferences, seminars, workshops and training sessions offer education in the conflict-resolution process. Their sixteen-thousand volume library covers all methods of dispute resolution. A partial list of publications includes Arbitration Journal, a quarterly; Arbitration Times, a quarterly; and specialized pamphlets, manuals, films, videotapes and books. An annual meeting is held in the spring in New York City.

- American Bar Association Standing Committee on Dispute Resolution
  1800 M Street NW, Suite 790
  Washington, DC 20036
  Phone: 202-331-2258
  Telefax: 202-331-2220

This is a committee of lawyers, judges, law professors and other legal professionals. They operate an informational clearinghouse on dispute resolutions, providing technical services and coordinating worldwide dispute-resolution programs. The agency encourages state and local bar associations to participate in dispute-resolution activities. There is a library of five hundred journals and documents. Periodic publications include *Dispute Resolution and Dispute Resolution Directory.*

- Community Dispute Services
  140 West 51st Street
  New York, NY 10020
  Phone: 212-484-4000

This service of the American Arbitration Association adapts traditional dispute-settling techniques to meet the needs of institutional groups and to help them develop their own techniques. It assists in disputes involving job discrimination, welfare-agency procedures, tenant-landlord disagreements, student-faculty-administration-community conflicts and merchant and consumer problems. Training programs on dispute resolution techniques are held for landlords and tenants, students, teachers, school administrators, consumers and retailers, community representatives and representatives of governmental agencies. A third-party neutral panel is maintained for Community Disputes Settlement.

- Conflict Resolution Center International

  7101 Hamilton Avenue
  Pittsburgh, PA 15208
  Phone: 412-371-9884
  Telefax: 412-371-9885

This group supports mediators and other conflict-resolvers attempting to settle interracial, tribal, ethnic, religious or other disputes. Its goals are to build conflict-resolution principles, knowledge, and techniques, and to create a network of experts to support, analyze and assess the work of conflict-resolvers. The group conducts workshops, maintains a library, provides guidance materials and tracks activities of conflict-resolvers. Conflict Resolution Center International provides the following computerized services: annotated listings of resource materials on conflict resolution; publications online; and a referral database of conflict resolution interveners, trainers and consultants. Publications include *Conflict Resolution Notes*, a quarterly.

- Institute for Conflict Analysis and Resolution

  George Mason University
  4400 University Drive
  Fairfax, VA 22030-4444
  Telephone: 703-993-1300
  Telefax: 703-993-1302

ICAR focuses on conflict intervention and resolution, with particular focus on cross-cultural conflict, sociological approaches, political violence and the ethics of conflict resolution. Its research has been published in books, journals, reports, papers and tapes. ICAR offers an M.S. degree program in conflict management and a Ph.D. in conflict analysis and resolution. ICAR conducts biweekly seminars and professional conferences. A five-hundred-volume library is maintained on conflict analysis and resolution at the interpersonal and international levels.

- Institute for Mediation and Conflict Resolution

  99 Hudson Street, 11th Floor
  New York, NY 10013
  Telephone: 212-966-3660
  Telefax: 212-966-3644

The objectives of the Institute for Mediation and Conflict Resolution are to mediate community conflicts; train people in mediation techniques and conflict resolution skills; and design dispute settlement systems. The agency is supported by foundation grants and contracts, to which community disputants can turn for assistance on a voluntary basis. The agency maintains a speakers' bureau and compiles statistics. A quarterly dispute-resolution forum is held.

- National Academy of Conciliators

  1111 West Mockingbird Lane, Suite 300
  Dallas, TX 75247
  Telephone: 214-638-5633

This is a group of professionals offering dispute-settlement consulting and training services. They promote alternatives to litigation; provide skills-development programs for independent third parties involved in dispute settlements; and promote preventive dispute-settlement

programs. The group handles human rights, family, consumer, environment and labor-management disputes. The National Academy of Conciliators maintains a library of monographs on mediation and arbitration, publishes the periodical *Between the Lines* and holds periodic regional conferences.

- National Institute for Dispute Resolution

  1901 L Street NW Suite 600
  Washington, DC 20036
  Telephone: 202-466-4764
  Telefax: 202-466-4769

This institute promotes dispute settlement without litigation through mediation and arbitration. It also promotes research and development of innovative practices and techniques of dispute resolution. The institute's goals are to improve the efficiency, fairness and effectiveness of how Americans resolve disputes. It funds efforts to develop new methods of using dispute-resolution processes to settle conflicts and solve problems. The agency also encourages regulatory negotiation in multiparty public policy disputes. Publications include *Dispute Resolution Forum*, 3-4/yr.; *Dispute Resolution Education and Training* and *Dispute Resolution in America.*

- Program on Conflict Resolution

  University of Hawaii at Manoa
  Social Science Research Institute
  2424 Maile Way
  Porteus Hall 704
  Honolulu, HI 96822
  Telephone: 808-948-8930

The activities of this group include dispute settlement and dispute-resolution programs, with a focus on community and family disputes, dispute management in schools and courts, comparative disputing in Asia and the Pacific, and public disputes. The program publishes its research results in its Working Papers Series, Occasional Paper Series, and *Update*, a newsletter.

- Society of Professionals in Dispute Resolution

  815 15th Street NW, Suite 530
  Washington, DC 20005
  Telephone: 202-783-7277

The Society of Professionals in Dispute Resolution serves as a clearinghouse. Its goal is to promote the acceptability and increase public understanding of negotiation, collective bargaining and other dispute-resolution procedures. It also promotes the roles of neutrals in the dispute-resolution process; neutrals include arbitrators, mediators, hearing examiners and fact finders in many types of dispute resolution. The agency holds seminars, an annual convention (October) and dispute-resolution skills trainings. Publications include annual conference proceedings, a membership directory, a quarterly newsletter and various papers.

## Nonprofit Management

- Accountants for the Public Interest
  1012 14th Street NE, Suite 906
  Washington, DC 20005
  Telephone: 202-347-1668
  Telefax: 202-347-1663

The national office provides referrals to 20 local groups. They encourage accountants to volunteer their time and expertise to nonprofit organizations, small businesses and individuals who otherwise would not have access to accounting services. Their publications include *What a Difference Nonprofits Make: A Guide to Accounting Procedures* and *Let's Get Ready for Your Auditor: A Guide to the Nonprofit Audit.*

- Amherst H. Wilder Foundation
  919 Lafond Avenue
  St. Paul, MN 55104
  Telephone: 612-642-4022

The Wilder Foundation's Community Services Group works to strengthen the capacity of individuals, organizations and other groups to improve their communities. Three proven step-by-step guides for nonprofits are *Strategic Planning Workbook for Nonprofit Organizations, Marketing Workbook for Nonprofit Organizations* and *Collaboration Handbook: Creating, Sustaining and Enjoying the Journey.*

- Channing L. Bete Company
  200 State Road
  South Deerfield, MA 01373-0200
  Telephone: 800-628-7733

Channing L. Bete Company's publications are designed to help people reach their goals through personal growth and community action. It is the publisher of Scriptographic Books, including such titles as *The A-B-Cs of Parliamentary Procedure, How To Have Successful Meetings, How to Develop Your Leadership Skills* and *Be A Volunteer. A New Real Story Series* includes four titles for people living with AIDS: *I Wish We Had Listened: A Gay Man's Story about AIDS, AIDS and My Family: A Hispanic-Latino Man's Story, My Brother Got AIDS* and *My Sister Got AIDS* (the latter two about African-Americans).

- Independent Sector
  1828 L Street NW
  Washington, DC 20036
  Phone: 202-223-8100

The goal of Independent Sector is to maximize national not-for-profit initiatives to better serve people, communities and causes. Its catalog offers books, reports, scholarly analyses and other publications designed to help leaders of volunteer action expand their fund raising results and improve their organizations' effectiveness. Independent Sector's three best sellers are *Giving and Volunteering in the United States, Nine-Part Nonprofit Management Series* and *The Board Member's Book.*

- Jossey-Bass Publishers
  350 Sansome Street
  San Francisco, CA 94104-1310
  Telephone: 415-433-1767
  Telefax: 413-433-0499

Jossey-Bass's publishing agenda reflects a sense of social responsibility and the goal of making a difference. The

company maintains links to the communities for whom it publishes, handling the challenges present in schools and colleges, hospitals and health care systems, and nonprofit and public institutions. Its catalog lists many titles on nonprofit management.

- National Center for Nonprofit Boards

  2000 L Street NW, Suite 510
  Washington, DC 20036
  Telephone: 202-452-6262
  Telefax: 202-452-6299

The goal of the National Center for Nonprofit Boards is to improve the effectiveness of nonprofit organizations in such fields as public policy, youth development, health and medicine, and social welfare by improving their governing boards. The center also assists nonprofit organizations in organizing and designing workshops, training programs and conferences, and operates an information center. A list of NCNB's books, booklets and audiotapes is available on request.

- Public Management Institute

  358 Brannan Street
  San Francisco, CA 94107
  Telephone: 415-896-1900

The PMI Nonprofit Executive Review focuses on corporate giving, nonprofit management, fund raising, and personnel and office management. Its catalog lists books, directories, office products, tools, handbooks, workbooks, computer software training programs and training books.

- Rainbow Research, Inc.

  621 West Lake Street
  Minneapolis, MN 55408
  Telephone: 612-824-0724
  Telefax: 612-824-0429

Rainbow Research's mission is to "promote the increased effectiveness and impact of socially-concerned organizations in responding to social problems." Its areas of concentration are community-building basics, neighborhood revitalization, philanthropy, community economic development, stretching official resources, strengthening community responses and nonprofit organizational effectiveness. A publication catalog is available on request.

- Sage Publications

  Society for Nonprofit Organizations
  6314 Odana Road, Suite 1
  Madison, WI 53719
  Telephone: 608-274-9777

The purpose of the Society for Nonprofit Organizations is to provide a forum for the sharing of information, knowledge and ideas on improving and increasing the productivity of nonprofit organizations and their leaders. The Society is comprised of executive directors, board members, staff, volunteers and other professionals. The agency operates a library of books, periodicals and tapes about operating effective and efficient nonprofit organizations. It sponsors workshops and seminars on nonprofit management and leadership. Publications include *Nonprofit World: The National Nonprofit Leadership and Management Journal*, a

bimonthly, and the *Society for Nonprofit Organizations-Resource Center Catalog.*

- United Way of America

  701 North Fairfax Street
  Alexandria, VA 22314
  Telephone: 703-836-7100
  Telefax: 703-683-7840

  The United Way's local organizations in the United States provide local, regional and national program support and consulting in the areas of budgeting, management, fund distribution, planning and communications. Staff and volunteer development training is administered through the National Academy for Volunteerism. The United Way of America provides national media support for members. The National Corporate Leadership Program promotes fundraising by cultivating increased corporate giving. A publication list is available on request.

# NOTES

U.S. Department of Health and Human Services
Public Health Service

HRSA

Health Resources and Services Administration
Bureau of Health Resources Development
Division of HIV Services

*Prepared by:* John Snow, Inc.
Ryan White CARE Act Technical Assistance Contract
#240-93-0046

JSI